

# HIV/AIDS

POVERTY AND PASTORAL CARE AND COUNSELLING



V H U M A N I   M A G E Z I

HIV/AIDS, Poverty  
&  
Pastoral Care & Counselling

*A home-based and congregational  
systems ministerial approach in Africa*

VHUMANI MAGEZI



*HIV/AIDS, Poverty & Pastoral Care and Counselling: A home-based and congregational systems ministerial approach in Africa*

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# Preface

*...challenging theology to rethink its major premises about self and society (Miller-Mclemore 2003:xi).*

**T**he basic premise of this book is that the congregation is the key to providing home-based pastoral care support to HIV-positive people in poor contexts. In so doing, the church does not only perform a social function to poor HIV/AIDS-affected families, but it also acts in accordance with the calling of mediating God's Kingdom (*diakonia*), thus spreading the gospel, and showing unconditional sacrificial love and compassion. The church embodies the gospel, which is the instrument of hope and salvation to despairing people living with HIV/AIDS in the community.

This book attempts to underline pastoral care as a congregational responsibility and not only that of the pastor. The paradigm shift of pastoral ministry from the professional pastor to becoming the responsibility of the whole congregation strengthens the case for congregational home-based pastoral care ministry. The congregation should design a home-based care ministry that functions as an arm of the church in providing support to families and homes affected by HIV/AIDS.

It is presupposed in this book that it has been said, preached and written that the church should be involved in HIV/AIDS care and counselling, which is largely the support function being advocated in this book, but many Christians are still not involved. Among the reasons for this failure is that the current home-care models fail to address the context of poor people, who are the most susceptible and vulnerable to HIV/AIDS. Poverty and HIV/AIDS are intricately linked; hence to be meaningful, ministerial approaches should focus on both issues.

Furthermore, there seems to be no well-articulated theology to inform ecclesiological and congregational HIV/AIDS ministries. Hence, this book attempts to carefully articulate a theology of family derived from Scripture to drive congregational home-based care ministry. In application, the theology draws from the natural African potential (i.e. extended family interconnectedness) in ministry design.

It is argued explicitly and implicitly in this book, based on the inclusive nature of the pastoral care function, that the whole congregation should be involved in loving and providing care (support) for HIV/AIDS-affected people in the community. The suggested practical way to do this is to begin a home-based pastoral care ministry. The proposed model is simply called **“congregational/church home-based pastoral care”**, but according to Uys’s (2003:5-7) classification, this falls under “single service home-based care”. The model draws from Uys’s three models (i.e. integration, single service and informal home-based care).

The congregation, however, in attempting to provide home-based pastoral care support, faces another hurdle, namely that of poverty alleviation. The church/congregation therefore assumes the *paraklesis* metaphor (i.e. comforting HIV/AIDS-affected people, and advocating and speaking for HIV/AIDS-affected poor people). It networks with other players (government, NGOs and other churches) in order to address the plight of HIV/AIDS poor people holistically.

In theory formation on the importance of a systems approach (i.e. congregational system care) it is argued that the theological principle of *koinonia* is fundamental to establishing a caring community and support system that promote faith maturity and spiritual development to the affected people. Thus, in spite of living with HIV/AIDS, the person becomes conscious of God’s faithfulness, that He (God) is present and shares the suffering and pain through his woundedness in Christ, thereby bringing healing. The historical events of incarnation (Jesus’ identification with human weaknesses and problems), crucifixion (paradox of Jesus’ power) and resurrection (Jesus’ victory over all forces) are evidence of God’s involvement with humanity. The counselling “encounter” therefore should theologically be directed by the eschatological perspective in order to promote hope.

The basic theological assumption for the study is that the fulfilled promises of the gospel directed by pneumatology provide a meaningful framework in order to cope with the HIV/AIDS pandemic in a constructive way. Hope emanating from eschatology is a key factor in both prevention care, home-based care and terminal care. It opens up new dimensions to cope with life, despite severe human suffering. It connects ethics with the aesthetics of human dignity.

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# *I.*

## *Introduction*

### *1.1 The Challenge of HIV/AIDS, Poverty and Home-Based Care*

#### **1.1.1 Introduction**

The prevalence of HIV/AIDS is high among poor people. The disease strikes very hard in poor countries, and in developed countries the highest incidence is among the poor minority. UNAIDS called it a disease of poverty (World Bank 2002:2)<sup>1</sup> and Sub-Saharan Africa is the second poorest region in the world after South Asia (Gibson and Sandenbergh 2002:17). Therefore, as HIV/AIDS cases escalate in Sub-Saharan Africa, poorly equipped African hospitals and staff are failing to cope. People living with HIV/AIDS are “often discharged home to die because the hospital staff can do nothing further for the patient or because they feel scarce resources are better utilised on someone with greater chances

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<sup>1</sup> The Department of Social Development publication, *Population, HIV/AIDS and Development: A Resource Document* (2003), which is a collaborative report by the Department of Social Development and the Centre for the study of AIDS, University of Pretoria, stresses that “All evidence points to the HIV/AIDS epidemic being at its most intense and generalised among the poor, affecting the under-employed and unemployed the most” (2003:20).

of recovery” (Jackson 2002:232). Also, some people living with HIV/AIDS may prefer to be at home with their families rather than in hospitals.<sup>2</sup>

But when the people are discharged to go home, the poor families get very little support<sup>3</sup> from the government and other social systems (Uys 2003:7). Smart (Online) aptly notes:

*In some developing countries, patients with HIV who have accessed primary care services from government-supported hospitals simply don't receive palliative care because linkages between these government institutions, community-based organizations and other potential care providers simply do not exist.*

The situation, therefore, creates intense physical, psychological, social and spiritual pressure to the affected<sup>4</sup> family<sup>5</sup>. In this respect, Miller-Mclemore and Couture (2003:xi), introducing the book entitled *Poverty, Suffering and HIV/AIDS*, which is a record of papers delivered at the International Academy of Practical Theology at Stellenbosch, South Africa, 2001, posed crucial and fundamental reflective questions for theology. Thus,

*How do the churches relate to society? What does the problem of global and local poverties mean for the practices of ministry within the church? And how are these relationships and practices grounded in Biblical and theological perspectives?*

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<sup>2</sup> Ncube's (2003:104) article "Responsibility in Inculturation: The healing Ministry in a Zulu Context" focuses on how HIV/AIDS fits into the Zulu context and worldview, which may be the general case in Africa. He attests to the fact that it is important for Zulus or African people who are seriously sick (including HIV/AIDS) that they should come *azofela ekhaya* (to come and die at home).

<sup>3</sup> Such support includes ongoing emotional and spiritual counselling, financial assistance, help with food, cooking, cleaning, wound care, hygiene, symptom assessment, pain and symptom management, identification of specific opportunistic infections, etc.

<sup>4</sup> Affected people refers to the HIV-infected person and the family caregivers.

<sup>5</sup> The Department of Social Development, South Africa (2003:42) further observed and commented that an analogy can be made between the impact of HIV/AIDS on the body and its impact on society's core institution, the family. In attacking the immune response of the body, HIV sets in motion a series of infections that exhaust the body's reserves, inhibit its capacity to resist disease and force it to use up essential muscle and fat in a desperate struggle for life until all is consumed. In attacking adults in their core productive and reproductive years, the social impact of the epidemic is the destruction of the family, a core institution that is at the centre of sustained human existence. As families try to defend themselves against the epidemic, they deplete their reserves, reducing their food intake and their capacity to meet their general care responsibilities. In their struggle to survive they lose anchor, as the people, capacities and material necessities that make collective life possible are consumed, stripping the family of its basic conditions of existence. This process continues through society, eroding if not destroying all levels of social organisation. In such a context, without strategic intervention, the family, like the body, cannot withstand the onslaught and human as well as social survival is threatened.

### 1.1.2 The Problem

In the light of the above introduction, the following questions help to focus this book:

- ✧ What is the link between poverty and the HIV/AIDS pandemic in an African context?
- ✧ In terms of crisis management, how can pastoral care play a role in providing a support system to poor families, especially during the crisis stage as well as during the final stage of terminal care?
- ✧ How can the concept of home-based care be applied to a model in which the congregation becomes a caring community, reaching out to the needs of HIV-positive people without the luxury of a sophisticated medical care system?

### 1.1.3 The Hypothesis

In order to provide a support system to people suffering from HIV/AIDS within a poor community setting, the pastoral ministry should move away from a very sophisticated counselling room approach to a congregational<sup>6</sup> systems<sup>7</sup> approach, which is focused not only on the congregation but also on the needs, pain and suffering of the community and society. For this approach, a model of home-based care<sup>8</sup> is proposed.<sup>9</sup> Through designing an HIV/AIDS home-based

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<sup>6</sup> There is a paradigm shift in pastoral care from the “professional pastor” approach to mutual care of believers, i.e. faith community care (*koinonia*) (Crabb 1979; Louw 1998). This is in line with Hendriks’s (2004:14-16) argument in *Studying Congregations in Africa*. He rightly emphasises that the congregation should be the fundamental locus of congregational studies, which in our case is congregational (*koinonia*) care. His arguments can be summarised as follows: firstly, the congregation is the first and foremost manifestation of the church – if it fails, then there is little hope elsewhere. Secondly, a congregational (*koinonia*) focus implies empowering members (laity), which enables congregations to grow spiritually rather than to be mere recipients (which makes them spiritual dwarfs – immature). Thirdly, it allows for congregation members to act and respond in accordance with the realities of their situations – the reality of diversity and pluralism. Fourthly, due to globalisation, the focus on congregations allows people (members) to deal with issues in their own environments, as these realities are in and around them, e.g. HIV/AIDS and poverty. Fifthly, it promotes a bottom-up approach in which people participate on issues that concern them.

<sup>7</sup> Augsburger (1986:178) states that a system is a structure in process; that is, a pattern of elements undergoing patterned events. The human person is a set of elements undergoing multiple processes in cyclical patterns as a coherent system. Thus a system is a structure of elements related by various processes that are all interrelated and interdependent. A systems approach does not focus on the person and psychic composition, but notices a position held by a person within a relationship (Louw 1998:74), which makes it crucial in Africa, considering the people’s connectedness. A broken relationship affects the whole being.

<sup>8</sup> The AIDS Bulletin (2004:4) argues that home-based care is identified as one of the non-ARV options, which should be scaled up with the same vigour as ARV. And it is being ignored as a proven cost-effective intervention in the rush for ARVs.

<sup>9</sup> Home-based care done within the network of other prevailing community relationships.

pastoral care ministry, the congregation (*koinonia* of believers)<sup>10</sup> could reach out and provide support to the affected people (enfleshment of *agape*), which is the calling of the church. In so doing, the church does not only perform a social function to the poor HIV- and AIDS-affected families, but it also acts in accordance with the calling of mediating God's Kingdom. Thus, spreading the gospel (Word and deed), showing unconditional sacrificial love and compassion, which is enfleshment or embodiment<sup>11</sup> of the gospel. The identification with the suffering of the person dying of HIV/AIDS should be viewed as instrumental to home care and the enactment of salvation, which is the impetus of hope.<sup>12</sup>

The presupposition for a home-based model is that the more one has to deal with poverty and is exposed to the suffering of people in an African setting or rural context, the more pastoral care should make use of and draw upon the so-called "natural" and "immediate" sources of people within the community. In order to do this, one should understand African spirituality as a people-oriented, interrelational system.

## *1.2 The Goal of the Book*

The book outlines how HIV/AIDS home-based pastoral care and counselling within a congregation can be done effectively to provide a support structure for poor people affected (i.e. the HIV-infected person as well as the family providing care) by HIV/AIDS. This is done within an awareness of the impact of the HIV/AIDS pandemic within the African context. In this regard, an African perspective and reflection play a decisive role as well as an understanding of the basic worldview and philosophy of life within African spirituality.

## *1.3 The Rationale for the Book*

The HIV/AIDS pandemic gives cause for concern for all people in Sub-Saharan Africa. It is hard for one not to have witnessed an HIV- and AIDS-related death, and the situation is compounded by the intricate relationship between the disease and poverty. Poverty provides the social context within which the pandemic flourishes in Africa and South Africa (Pienaar 2004:6; UNAIDS 4<sup>th</sup> global report 2004; Department of Social Development 2003:20). The link is

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<sup>10</sup> The word *koinonia* refers to the fellowship, association, community, communion, joint participation of believers (Thayer 1977:2844). And it is used in this research to describe the mutual care of the faith community members.

<sup>11</sup> The church is challenged regarding HIV/AIDS to recognise the need to overcome fears, to be signs of hope in our afflicted world, to share our pain and the pain of others, to fight denial, to work for reconciliation and hope (Munro 2003:48).

<sup>12</sup> God's healing grace is communicated through pastoral care metaphors (i.e. shepherd, servant, paracetic and wisdom); by so doing, both the pastor and parishioners become crucial vehicles of God's healing grace amid HIV/AIDS despair.

clearly stated in a report by the UNAIDS (World Bank 2002:2 only 2001) on the distribution of HIV/AIDS around the world:

*AIDS is a disease of poverty in the sense that most of the people with HIV or AIDS are poor. The disease struck very hard in poor countries: 96 percent of infected people are in the developing world, and 70 percent are in Sub-Saharan Africa alone.*<sup>13</sup>

Furthermore, the World Bank report asserts that studies in developed countries show that AIDS is most prevalent among the poor.

Sub-Saharan Africa being the second poorest after South Asia (Gibson and Sandenbergh 2002:127), and leading in HIV/AIDS cases, the challenge is far from being the responsibility of only governments or social workers. The church, especially in the area of pastoral care and counselling, is inevitably expected to offer support, love and hope to HIV- and AIDS-affected people. "In fact, pastoral care is one of the services generally available in Sub-Sahara Africa" (Smart online). It is the characteristic of the Church to love (*agape*) and care. And it is into this challenging task of supporting (showing solidarity with) HIV/AIDS-affected people within their context, in our case one of poverty, that pastoral care is expected to be implemented.

The theological presupposition of the study is that God is faithful in every situation, even in HIV/AIDS infection due to his (God's) identification with suffering people. The introduction of such a theological principle is connected to a very specific God-image: God's identification with suffering people due to his own woundedness through and within the cross of Christ. Pastoral care should therefore proceed from a thorough understanding of a *theologia crucis*. Furthermore, pastoral care should be a conduit of God's faithfulness in order to bring hope to the people suffering from HIV/AIDS within a context where poverty prevails. Pastoral therapy, which operates from an eschatological perspective, should try to foster a vivid hope (Louw 1998: 449). This hope can play an important role in the process of coping with the infection in a constructive way and manner.

#### 1.4 The Proposed Contribution

The HIV/AIDS pandemic is a big challenge in Africa, especially in Sub-Saharan Africa. The hospitalisation paradigm of caring for the sick is failing to cope. Hence, the home-based care paradigm for HIV/AIDS caring could be a possible

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<sup>13</sup> The AIDS Bulletin (2004:3) also attests to the correlation between HIV/AIDS and poverty in saying: "We know that HIV/AIDS is the quintessential disease of poverty. The pandemic has its greatest impacts on the poor and most vulnerable populations: those with no access to clean water and sanitation; poor nutrition and overall health status - and those who are constantly challenged by a variety of other infections".

solution.<sup>14</sup> In this regard, however, the communal concept of Africans – *umunthu ngumunthu ngabantu* (a person is a person because of people, or a person is a person through other persons) – is instrumental and an invaluable building block concept contributing to successful and effective congregational (*koinonia*) home-based care.<sup>15</sup> The church, in executing her pastoral care role, should utilise this rich and advantageous concept in addressing the needs of HIV/AIDS-affected people. The book, therefore, carefully explores and reports on the age-old activity of home care or family care in Africa and the biblical tradition, and the challenge of poverty, thereby drawing lessons on how pastoral care and counselling can be undertaken effectively to provide care and support HIV/AIDS-affected people.

### 1.5 Methodology

- ☞ The book is a product of a literature study. A sufficient number of sources were found on the issue of HIV/AIDS and its link to home-based care for a literature-based approach.
- ☞ The method of critical reflection as well as analysis and logical arguments was applied in order to understand the pandemic and to argue the hypothesis.
- ☞ A hermeneutical approach was followed in order to gain clarity on the link between the HIV/AIDS pandemic and theological reflection. Thus the method of interaction between theory and praxis, praxis and theory.
- ☞ Indirectly, the researcher made use of the method of participatory observation due to the fact that his context was reflected in his own subjective mindset. He originally comes from Zimbabwe and has been in South Africa for several years, where the immediate context of the HIV/AIDS pandemic impacts on his attitude and aptitude.

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<sup>14</sup> The available publications, however, do not adequately address the subject of home-based care. They either completely ignore it, or mention it in passing, e.g. the publications listed below:

Ackerman (2001), Barret-Grant *et al.* (ed.). (2003), Bate (ed.). (2003), Byamugisha *et al.* (2002), Cadwallader, A.H. (ed.), Dube (ed) (2003), Gennrich (ed.). (2004), Grenz and Hoffman (1990), Greyling and Murray (2004), Greyling (2001), Hunter (2001), \*Jackson (2002), Lachman (1999), Louw (2001), Pienaar (2004), Porte (2003), Shelp and Sunderland (1987a, 1987b), \*Van Dyk (2001, 2000), Van der Walt, (2004), Ward (2001), World Council of Churches document: *Facing AIDS: The challenge, the Churches' response*.

\* These authors mention home-based care but do not discuss it in detail. It seems the only publication that deals with the subject of home-based care is: Uys and Cameron's (ed). (2003) publication. The authors of the book rightly comment that it is the first book that addresses the subject. In addition, some publications on the general subject of HIV/AIDS are totally misleading. They claim to address the African scenario and yet they completely ignore it. An example is the publication by Mombe (2004), a Jesuit from the Central African Republic.

<sup>15</sup> Hence the concept that an individual does not exist on his/her own, for a person is a person through and with others (*umuntu ungumuntu ngabantu*). Similarly, in the Christian tradition, people live as a body of Christ (1 Cor 12).

- ∞ In terms of doing theology, practical theology is defined as a continuing hermeneutical concern discerning how the Word (Scripture) should be proclaimed in word and deed in the world (Hendriks 2004:19), which Louw (1998:4) referred to as “theology from below”. Hence, the following guidelines of doing theology echoed by Hendriks (2004:24) will be adopted:

Theology is about:

- ∞ The missional praxis of the triune **God**, Creator, Redeemer, Sanctifier, and
- ∞ About God’s body, an apostolic faith community (the **church**)
- ∞ At a specific time and place within a globalised world (a **wider contextual situation**)
- ∞ Where members of this community are involved in a vocationally based, critical and constructive interpretation of their present reality (**local analysis**)
- ∞ Drawing upon an interpretation of the normative sources of **Scripture and tradition**
- ∞ Struggling to **discern God’s will** for their present situation (a critical **correlation** hermeneutic)
- ∞ To be a sign of God’s kingdom on earth, while moving forward with an eschatological faith-based reality in view (that will lead to a **vision** and **mission** statement)
- ∞ While obediently participating in transformative action at different levels: personal, ecclesial, societal, ecological and scientific (a doing, liberating, transformative theology that leads to a **strategy, implementation and evaluation** of progress).

## 1.6 Outline

**Chapter 2** outlines a contextual understanding of HIV/AIDS in Africa. It argues that understanding the African worldview of sickness and how HIV/AIDS fits into this framework, coupled with accurate HIV/AIDS facts and information, is the key to effective pastoral care to HIV/AIDS-affected people. Thus this chapter provides the background information both on an African personalistic and a naturalistic understanding of HIV/AIDS that is crucial for caregivers in Africa. The discussion falls under the following subheadings: the strategic nature and effectiveness of the African church in disseminating HIV/AIDS information; facts on HIV/AIDS issues such as definition and description, origin, infection, transmission and statistics; infection progress; factors contributing to the rapid spreading of the epidemic; and an African worldview of sickness and how HIV/AIDS fits into the framework.

**Chapter 3** delineates the nature of the relationship between poverty and HIV/AIDS in Africa. The discussion falls under the following subheadings:

definition and description of poverty; biblical concept of poverty (both in Old Testament and New Testament); and interplay of poverty and HIV/AIDS.

However, since poverty and HIV/AIDS are global phenomena, it is insightful to consider the African scenario (i.e. the sub-Saharan region) in the light of global issues and processes. Therefore, Chapter 2 and Chapter 3, according to our definitional framework of doing theology, fall under: *God's body (faith community - the church) at a specific time and place within a globalised world (a wider contextual), where members (faith community) are involved in a critical and constructive interpretation of their present reality (local analysis).*

**Chapter 4** outlines a practical theological ecclesiology within a context of poverty and HIV/AIDS. It argues the assumption that for pastoral care to be effective and meaningful in addressing the plight of poor and HIV/AIDS-affected people, the church i.e. *koinonia*, should embody the metaphor of family, whose members, through a systemic relationship, have a responsibility to care for one another. The focus therefore ceases to be on the individual but on the whole community (system), which encourages care and support for one another. The congregation systems approach also helps congregations to shift from apathy to empathy, i.e. from non-involvement to active participation in the lives of the poor and HIV/AIDS-affected people, which is a translation of the gospel into reality (enfleshment of the gospel). The discussion falls under the following subheadings: definition and description of church; the practical theological nature of the church; church (*koinonia*) family systems approach; African extended family care system; biblical (both Old Testament i.e. Jewish, and New Testament) injunction and paradigm of care; comparison of biblical and African family caring; and change of attitude to the poor and HIV/AIDS-affected people.

According to the definition of theology, this entails *drawing upon an interpretation of the normative sources of Scripture and tradition, and struggling to discern God's will for their present situation (a critical correlation hermeneutic).* Thus the methodology of theory-praxis, praxis-theory.

**Chapter 5** outlines pastoral counselling intervention to people living with HIV/AIDS. It argues the assumption that pastoral counselling is the most appropriate approach, which deals meaningfully with healing and providing hope to people living with HIV/AIDS from the disclosure of their HIV status until death through faith-community (*koinonia*) care. By designating pastoral care metaphorically - shepherd, wisdom, servant and paraklesis - it embodies God's healing grace. The discussion falls under the following sub-headings: definition and description of pastoral care; counselling stages, pre- and post-HIV test counselling; the distinctiveness of pastoral counselling; a health relationship between psychology and the Bible; the nature of pastoral therapy; pastoral diagnosis/assessment; and basic counselling skills.



**Chapter 6** focuses on a design for a home-based pastoral care ministry as a responsive paradigm to the HIV/AIDS pandemic in Africa. The congregation within its community should erect structures that support HIV/AIDS-affected people in the church and outside (in the community). The selfless giving, unconditional sacrificial love and compassion taught in Scripture that is epitomised in the Lord Jesus Christ's sacrificial death on the cross for humanity should be the motivation for congregation members. The chapter assumes that by drawing lessons from the notion of the extended family in Africa, home-based care ministry is imperative to ministerial practice in Africa. The discussion falls under the following subheadings: home-based care – definition and description, advantages of home-based care, origin and models of home-based care; and home-based care ministry design.

Chapters 5 and 6 deal with how a church can give practical assistance in a context of poverty and HIV/AIDS, i.e. translating the theological and pastoral perspective to the reality of human suffering. Thus these chapters mean that a faith community (*kononia*) becomes: *a sign of God's kingdom on earth, while moving forward with an eschatological faith-based reality in view (that will lead to a **vision** and **mission** statement) and obediently participating in transformative action at different levels: personal, ecclesial, societal, ecological and scientific (a doing, liberating, transformative theology that leads to **strategy, implementation and evaluation** of progress).*

## *1.7 The Value of the Book*

It is envisaged that this book would be a resource for HIV/AIDS caregivers, faith-based NGO programme planners, church leaders and counsellors. Furthermore, it would encourage African churches to draw from their history and culture in order to help Christians to develop a practical approach towards those suffering from poverty and HIV/AIDS in ways that are familiar to the cultural context of Africans as well as being rooted in Scripture.

## II.

# *A Contextual Understanding of HIV/AIDS The African Scenario*

### *2.1 Introduction*

Christianity should be context- and situation-relevant in order to be effective. Hendriks (2001:76) underlines this idea in the article “Doing Missional Theology in an African Context”, in which he states that “Doing theology and being a church is a process where we accept that all theological formulations and institutional designs are influenced by their context”. Thus, theology is contextual. Couture (2003: xii), arguing along the same lines as Hendriks, states that “different parts of the world must develop practical theological methods that are the most responsive to the critical questions that are raised in particular locations”. Hence, it is important for us to reflect on the African HIV/AIDS context and scenario. This chapter therefore focuses on the African contextual understanding of HIV/AIDS.

The chapter proceeds from the assumption that understanding African people’s personalistic worldview of sickness (i.e. sickness caused by supernatural beings) and how HIV/AIDS fit into this framework is crucial for effective pastoral care. Thus, though African people may embrace naturalistic explanations (i.e. sickness caused by natural causes) of HIV/AIDS, it is interpreted within the personalistic framework. Therefore, crucial as the

naturalistic facts and information on HIV/AIDS may be, the African worldview should be understood as well.

Secondly, the chapter assumes that highlighting important HIV/AIDS facts and information and how they fit within the African worldview provides the core background information for the church to provide effective pastoral care support. But what is the HIV/AIDS information that a pastoral caregiver and counsellor should know in order to counsel effectively in Africa? What is the role of the African church<sup>1</sup> regarding HIV/AIDS information? And, importantly, what is the African worldview of sickness and how does HIV/AIDS fit into this framework?

## *2.2 HIV/AIDS Information and the Church in Africa: A Pastoral Resource for Caregivers*

The church in Africa should be aware of HIV/AIDS information. It is deplorable that church people (i.e. pastoral caregivers) and leaders should be ignorant about their HIV/AIDS context. An example of such deplorable ignorance was uncovered by Forster's statistics (cited by Brown 2004:59) in Malawi:

*[She] found that ministers of religion were seen to be not only among the least reliable as a source of information regarding HIV/AIDS, but they were also not perceived as being particularly credible nor trustworthy in terms of AIDS messages.*

The need for pastoral caregivers, who are congregation members, to be acquainted with HIV information is undoubtedly of strategic and paramount importance. People from different localities converge at church meetings for worship. According to the first comprehensive research in South Africa that was done by the Nelson Mandela HSRC study of HIV/AIDS (NMH), it was discovered that "Faith-based organisations were an important source of HIV/AIDS information and rated higher than AIDS organisations, youth groups and sports clubs" (2002:17). Hence the church should exploit this advantage to inculcate more knowledge that would hopefully lead to behavioural change. Besides, Mwaura (2000:96) in his article, "Healing as a Pastoral Concern", adds that "the pastor responsible for providing pastoral care has also a duty to be well informed about the disease for his/her irrational fear can cause additional pain and harm to the victims and those who attempt to care for them". The research report (NMH 2002:15) further underlined the value of information, saying:

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<sup>1</sup> The phrases African church and church in Africa synonymously refer to churches that are located in Africa. They can be mainline churches or African-initiated churches, but they experience the same challenges and opportunities.

*Better knowledge of transmission has been shown to have positive relationship with both prevention behaviours and positive attitudes to people with HIV/AIDS. This does not imply that knowledge is a sufficient condition of behaviour change and positive attitudes, but is necessary condition.*

Information should be disseminated to all church members in order for them to be aware of the crucial facts. Louw (1995:32-33) in his article, "Pastoral Care for the Person with AIDS in an African context" rightly states that "sobriety and realism have prevailed" regarding HIV/AIDS in Africa. And the focus of pastoral care (i.e. provided by the church) is now twofold: "*information, education, and the creation of adequate emergency services, care and support systems within local communities*" (my emphasis) (1995:33). HIV/AIDS information is no doubt crucial for the caregiving community. But, what is the HIV/AIDS information that pastoral caregivers are supposed to know in Africa?

Ackerman (2001:5), referring to the HIV/AIDS situation, argues that we are all people with HIV/AIDS because many of us are infected. Thus HIV/AIDS has become intricately entangled with our being. Therefore, the complex issues related to Africa's epidemic are intertwined with some African cultural issues and worldview. Hence, it is insightful to provide an overview of HIV/AIDS information (2.3) in the light of the African worldview (2.4).

### *2.3 HIV/AIDS: Definition and Description, Origin, Infection, Transmission and Statistics*

**HIV/AIDS definition and description:** AIDS is the acronym for acquired immune deficiency syndrome. It is a condition caused by HIV i.e. the human immunodeficiency virus. The HI virus enters the body from outside (i.e. it is acquired) and destroys the immune system that defends the body against infection. When the body's immunity is weakened, this is called immune deficiency. Because the body no longer has immunity to fight against any infection, it becomes open to any infection. A syndrome therefore "refers to a set or collection of specific signs and symptoms that occur together and that are characteristic of a particular pathological condition" (Van Dyk 2001:4). Rebirth African Art (Online) simply stated, "HIV/AIDS cause an immune-system breakdown rather than a specific disease, so people can die of any one of dozens of diseases that have been here in Africa for decades".

Although AIDS is called a disease, it is important to emphasise that it is not a specific illness, but a collection of many different conditions that manifest in the body because the HI virus has weakened the immune system. The body can no longer fight the pathogens that invade the body. Hence it is more accurate to define AIDS as a syndrome of opportunistic diseases, infections and certain

cancers - each or all of which have the ability to kill the infected person in the final stages (Shelp and Sunderland 1987:11; Grenz and Hoffman 1990:63-74; Van Dyk 2001:5).

However, for a general working technical definition, it is worthwhile to adopt the definition below by Avert (Online).

*The Centre for Disease Control (CDC) currently defines AIDS in an adult or adolescent age 13 years or older as the presence of one of 26 conditions indicative of severe immunosuppression associated with HIV infection, such as *Pneumocystis carinii* pneumonia (PCP), a condition extraordinarily rare in people without HIV infection. Most other AIDS-defining conditions are also "opportunistic infections" which rarely cause harm in healthy individuals. A diagnosis of AIDS is also given to HIV-infected individuals with a CD4+ T cell count less than 200 cells per cubic millimeter (mm<sup>3</sup>) of blood.*

While it may be necessary to flesh out this definition, for the sake of the researcher's and the intended theological audience's limited knowledge of the technicalities, we shall focus on less technical facts that are easily digestible and relevant for the discussion. What is crucial, however, is for caregivers to distinguish between AIDS and HIV. AIDS is the final stage of immunity depletion by the HIV [NOT: HIV=AIDS; but HIV will cause the AIDS condition]. AIDS is a condition that renders the body vulnerable and exposed to any kind of invasion (pathogens), because the HIV has eroded the body's defence system. However, the difficulty of distinguishing between HIV/AIDS in the discussion prompts the following question: why is it important to differentiate HIV from AIDS?

The response to the above question has implications for the HIV/AIDS caregivers, counsellors and infected people. It raises awareness among the affected people that being diagnosed as HIV positive is not a death sentence. There are still many more years to live, provided the person adopts the right attitude and behaviour. As for the counsellor, it allows him/her to offer precise or accurate guidance and constructive advice to HIV/AIDS-affected people. But what is the origin HIV?

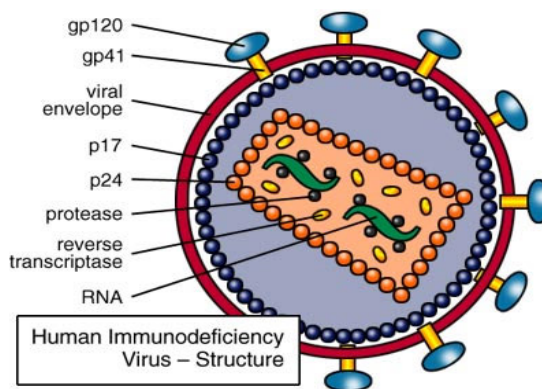
**HIV origin:** In the past people used to call AIDS a homosexual disease both in Africa and in the West. But most people now do not view HIV/AIDS in this way. There is consensus that the HI virus causes AIDS and the only way to trace the origin of AIDS is to trace the HI virus. However, the Origin of AIDS and the HIV group (Online) warned that in trying to identify where AIDS originated, there is danger that people may try to use the debate to attribute blame for the disease to a particular group of people or individuals or certain lifestyles. Therefore,

the quest to unveil the roots of HIV/AIDS should be dissociated from stigmatising and ostracising particular people.

There are many unfounded and speculative theories about the origin of HIV. For instance, some say the HI virus was developed as an instrument of biological warfare; it was being used by aliens from outer space to kill people of planet earth (Shelp and Sunderland 1987:7; Grenz and Hoffman 1990:35; Van Dyk 2001:6-8); it is God's punishment; it resulted from polio vaccines in central Africa (Jackson 2002:3-6), and many others. All these theories are suspect; hence, it is unwise to dwell on them. The question remains: what is the probable origin of HIV?

Regarding the origin of the HI virus, it has been scientifically established that the HI virus belongs to a group of viruses called lentiviruses. Lentiviruses other than the HI virus have been found in non-human primates (such as chimpanzees and African green monkeys). These other lentiviruses are known as "simian monkey viruses", i.e. simian immunodeficiency virus (SIV). Kober affirms that the link between the SIV and the HIV is generally accepted by scientists, i.e. HIV crossed species from primates to humans at some time during the twentieth century (cited in Van Dyk 2001:3-6).

The crossing occurred because certain viruses can pass from animals to humans, and this is called zoonosis. Therefore it is believed that HIV could have crossed over from chimpanzees to humans through their being killed for food or through vaccine (but evidence of vaccine seems to be rejected). There are no conclusive facts about how the virus crossed from one species to another. But the earliest instances of HIV infection are from a man in the Democratic Republic of the Congo (1959); the "British sailor from Manchester who died of an AIDS-related illness in 1959" (Lachman 1999:8); HIV was found in an African American teenager who died in St. Louis 1969; and HIV was found in tissue samples of a Norwegian sailor who died in 1976.



**Fig. 2.1:** Structure of the HI virus (Source: [www.avert.org/virus.htm](http://www.avert.org/virus.htm))

With such an avalanche of speculative data, it is wise therefore to accept the following comment on the origin of AIDS and HIV ([www.originofaids.com/2002:2](http://www.originofaids.com/2002:2)):

*We will probably never know exactly when and how the virus first emerged, but what is clear is that sometime in the middle of the twentieth century, HIV infection in humans developed into the epidemic of disease around the world that we now refer to as AIDS.*

Origin of AIDS.com (Online), in “The origin of AIDS and HIV may not be what you have learned”, surveyed the scientific data available and concluded with the words of prominent scientists. They wrote:

*Myers and his colleagues offered the following best explanation for the origin of HIV: “It is not far fetched”, they wrote, “to imagine the ten clades deriving from a single animal (perhaps immunosuppressed and possessing a swarm of variants) [as might have been the case with chimpanzees used in the process of vaccine manufacture] or from a few animals that might have belonged to a single troop or might have been gang caged together. The number of animals required is secondary to the extent of variation in the source at the time of zoonotic or introgenic event. The (vaccine) hypothesis makes a case for such a punctuated origin.*

Nonetheless, the conclusive fact backed by scientific research is that there are two HIV strains, HIV-1 and HIV-2. HIV-1, which is more virulent and has spread throughout the world, originated in the chimpanzee sub-species. A particular kind of chimpanzee is known to carry a virus quite similar in structure to the HIV. The HIV-2, which is less virulent, is found in West Africa and originated from the sooty mangabey monkey (Greying and Murray 2004). Once the HI virus was in the blood, the rapid and sudden spread of the HI virus was largely due to international travel, the blood industry and drug use (Jackson 2002; Van Dyk 2001, among many other writers). To close the debate on the origin of HIV, it is wise to note that wasting time arguing about who caused the fire while the house is burning is foolish. While knowing the perpetrator may be necessary, it will not put out the fire. The wisest thing is to call the fire brigade. So it is the same with trying to know the origin of HIV/AIDS. People are in a serious predicament. They should look ahead for ways to adapt. HIV/AIDS-affected people need care. (For a detailed discussion visit: [www.avert.org/origins.htm](http://www.avert.org/origins.htm))

**HIV infection:** The HIV-1 is believed to be the cause of infections in Central, East and Southern Africa, North and South America, Europe and the rest of the world. HIV-2 was discovered in West Africa (Cape Verde Islands, Guinea-Bissau and Senegal) in 1986 and it is mostly restricted to West Africa (Jackson 2002:145; Van Dyk 2001:5). Both viruses cause AIDS, but the difference is that

HIV-2 works slowly on the victim, thereby taking a long time for the victim to develop AIDS symptoms.

The immune system (i.e. the body's defence mechanism) has several different methods of fighting infections, some of which are the white blood cells, i.e. phagocytes and lymphocytes (T cells and B cells). The T4 or CD4 cells activate other cells to fight against infection in different ways. They also destroy the cells infected with viruses. And it is these (T4 or CD4) cells that are affected by HIV, thereby making them ineffective. In addition, HIV invades dendritic cells that alert the CD4 cells to the presence of the foreign bodies (i.e. infections). When they are destroyed, the response of the CD4 cells will be very weak. The destruction of the immune system means that infections can occur in the body unchallenged and multiply to cause serious diseases.

The complexity and unique challenge of HIV derive from its ability to mutate or change rapidly. HIV mutates or changes its outer layer so rapidly that it is extremely difficult to detect any similarity between the outer layers of one HI virus and the next. Because of this rapid mutation, the body cannot defend itself against the enemy, because its enemy is constantly changing its identity (Shelp and Sunderland 1987:11; Grenz and Hoffman 1990: 63-74; Van Dyk 2001). Louw (1990:37-38), in *Ministering and Counselling the Person with AIDS*, added, "The virus changes frequently and has the ability to adjust itself. Its genetic plasticity creates a very fluid situation and makes medical research difficult".

***Spreading HIV/AIDS:*** There are four body fluids that contain high HIV concentrations in an infected person and show evidence of transmission: blood, semen, vaginal fluid and breast milk. But saliva, tears, perspiration and urine have low HIV concentrations and there is no evidence of transmission. In fact, for HIV to be transmitted through them, they need to be present in large quantities, e.g. seven gallons of saliva. Therefore, transmission focuses on the four highly concentrated fluids that can be passed from the infected person to the next largely through sexual intercourse, blood transfusion, and by way of parent to child (mother to child).

***Sexual intercourse:*** HIV infection is mostly transmitted sexually through unprotected vaginal or anal intercourse (without a condom), and possibly but very rarely through oral sexual contact (Shelp and Sunderland 1987:9; Grenz and Hoffman 1990:23; Van Dyk 2001:18). In South Africa, which could also be the case in other African countries, sexual HIV transmission is responsible for 86% of cases (i.e. 79% heterosexually and 7% homosexually) (Greyling and Murray 2004). Thus HIV in Africa is chiefly transmitted heterosexually. HIV is transmitted when the virus enters the blood stream via the body fluids and connects to the CD4 cells. Women are more vulnerable to being infected with the virus because of physiological, anatomical and socio-economic factors, and



age.<sup>2</sup> Statistically, a single unprotected sexual encounter with an infected person is enough for an infection to occur.

*Contaminated blood:* The HI virus can be transmitted when a person receives contaminated blood during blood transfusion; this accounts for 1% of the HIV cases in South Africa. Even though there are far fewer cases of HIV transmission through blood transfusion than sexual transmission, there are cases where people have been infected through contaminated blood. To avoid such incidents, the WHO stipulated strict precautions to guard against blood contamination by the HI virus.<sup>3</sup> The blood should be thoroughly screened.

Apart from blood transfusion, people who share syringes and needles to inject drugs are also at high risk. UNAIDS 2000 estimated that nine out of ten cases of transmission of HIV among heterosexuals in New York can be traced back to having sex with a drug user who receives drugs intravenously (Van Dyk 2001:25).

Needles, syringes and other sharp instruments either in hospitals or used in piercing or cutting, such as circumcision, may expose people to the HI virus.

*Parent to child (i.e. direct mother-to-child transmission):* Mother-to-child HIV transmission is responsible for HIV cases in young children, and accounts for 13% of the HIV cases in South Africa. However, mother-to-child transmission (MTCT) is preferably called parent-to-child transmission (PTCT), since the mother might have acquired the HIV from the spouse. PTCT transmission takes place during pregnancy (approx. 6%), during labour and delivery (approx. 18%) and during breastfeeding (approx. 4%) (Ray *et al.* 2002:21; Greyling and Murray

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<sup>2</sup> **Physiologically:** The lining of the vagina strengthens at the age of 15-16 at the stage when the body produces hormones to prepare a girl's body for sex. Therefore, if a girl has sex before that, there are high chances of lesions, thereby increasing the risk of infection. Furthermore, the PH balance and different bacteria in the vaginal area, if altered, provide a suitable environment for the HIV. Also, due to periodical discharges, she may not know when she has an STI, thereby increasing the risk of infection.

**Anatomically:** Women are receivers of semen; they experience more trauma to their sexual organ, which leads to lesions, especially during dry sex; and women's genitals are mostly internal and they won't notice any lesion or discharge.

**Socio-economic:** Often in many cultures women are economically disadvantaged and they have little power to negotiate for contraceptives; they are often objects of abuse; and in rural areas there is no access to health care services for the treatment of STI that reduces HIV transmission.

**Age:** Women are more susceptible to infection at a younger age because their bodies are not ready for sex and yet they become sexually active early; and the young girls also prefer having sex with older men who give them gifts and the older men in turn prefer young girls too.

<sup>3</sup> The blood of all donors is tested every time they donate blood; with each donation the donor is asked to complete a questionnaire on his/her sexual activities to determine whether he/she should donate; all blood products, such as factor viii and plasma, are subjected to heat treatment or chemical cleansing processes that destroy all possible viruses; where possible blood transfusion services use donors about whose lifestyles they are relatively certain, their blood is nonetheless still tested; and sterile needles are used every time.

(2004:3.4/23). HIV infection can occur in early pregnancy and many of these pregnancies end in miscarriage and stillbirths. But the main transmission of HIV during pregnancy occurs during the last three months or during labour and delivery. Postnatal HIV infection occurs through breastfeeding.

Administering antiretrovirals, e.g. Nevirapine, controls transmission during pregnancy; delivery through caesarean operations controls infection during delivery; and safer breastfeeding<sup>4</sup> or replacement infant feeding controls postnatal infection. However, though PTCT can be reduced, it is hampered by poor antenatal care in Africa because of the poor medical facilities prevalent among the vulnerable poor HIV/AIDS majority. And replacement feeding for the infant has a cultural stigma. Ray *et al.* (2002:x) in *Parent to Child Transmission of HIV* highlight similar issues in Africa in agreement with Nierkerk's (2003) article "Mother to Child transmission of HIV/AIDS in Africa: Ethical problems and Perspectives" on the complexities of PTCT. They underline that:

*HIV-positive women who have access to services can also receive advice and support on how to reduce the risk of HIV transmission to their infants after delivery. Both the benefits of breastfeeding and the risk transmission of HIV through milk are of greatest significance in the first six months of an infant's life. Although avoiding breastfeeding completely is the most effective way to avoid transmission, it carries other risks to infants and complications for mothers. Replacement feeding can be unsafe and expensive, and it increases the risk of infectious diseases. In areas where breastfeeding is the norm, mothers may be under pressure to conform to avoid suspicion and the stigma attached to HIV-positive status. This can result in mixed feeding (switching between breastfeeding and replacement feeding), which increases the risk of transmission because the infant gut can become damaged and provide entry for HIV infection. WHO recommends that replacement feeding should only take place where conditions make it acceptable, feasible, and affordable, sustainable and safe (Ray et al. 2002:x).*

In fact, besides the affordability, accessibility, sustainability, feasibility that the writers mention, cultural acceptability is crucial. Failure to breastfeed a child in rural Ndau Zimbabwe, to which tribe the researcher belongs, means the mother is a witch, adulterer or has committed other socially unacceptable practices. Hence, a mother would rather stick to the societal norms than the safe practice, even though this means putting the child at risk.

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<sup>4</sup> Safer breastfeeding refers to only the mother breastfeeding the infant.

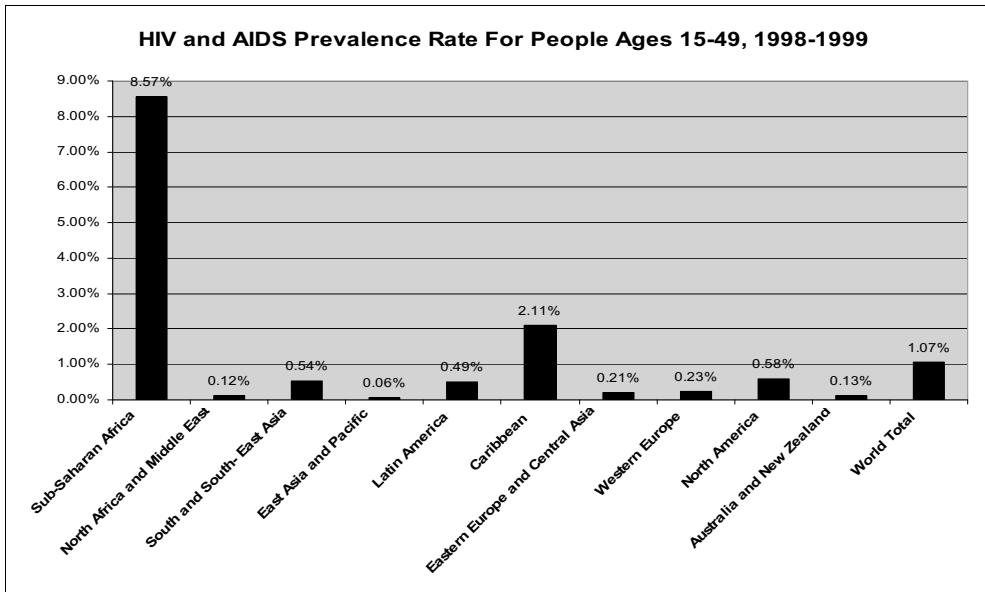
Finally, it is important to point out that, though the semen, vaginal fluid, milk and blood have high HIV concentrations, which makes transmission possible, there are other conditions that should be met, i.e. human body temperature, moist environment, no contact with atmosphere, and right PH. The other risk-increasing conditions are entry point (opening or cut), sexually transmitted infections, and quantity of virus.

**Table 2.1** HIV/AIDS statistics: HIV/AIDS by region (Source: <http://www.avert.org/worldstats.htm>)

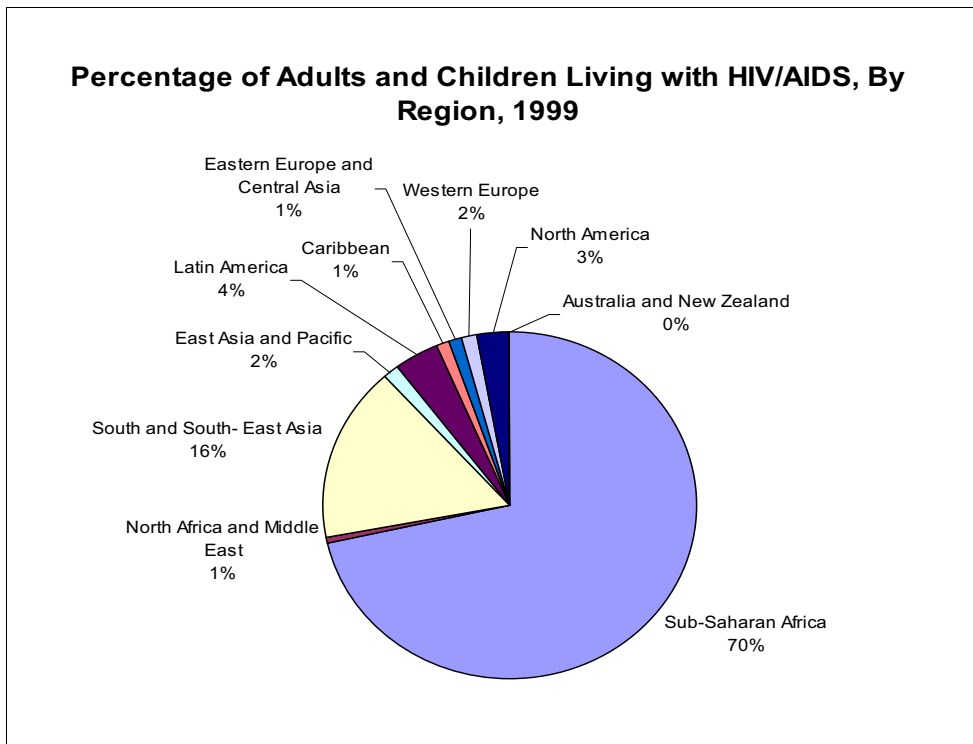
Region	Epidemic started	# Adults & children living with HIV/AIDS	Adult prevalence rate *	# Adults & children living infected with HIV/AIDS
Sub-Sahara Africa	Late 70s-early 80s	25-28.2 million	7.5-8.5%	2.2-2.4 million
North Africa and the middle East	Late 70s- early 80s	470 000-730 000	0.2%-0.4%	35 000-50 000
South and East Asia	Late 80s	4.6 -8.2 million	0.4- 0.8%	330 000-590 000
East Asia and Pacific	Late 80s	700 000-1.3million	0.1 %	32 000-58 000
Latin America	Late 70s-80s	1.3-1.9 million	0.5-0.7%	49 000-70 000
Eastern Europe and central Asia	Early 90s	1.2-1.8 million	0,5%-0.9%	23 000-37 000
Western Europe	Late 70s-Early 80s	520 000-680 000	0.3-0.3%	2600-3400
North America	Late 70s -early 80s	790 000-1.2 million	0.5-0.7%	12 000-18 000
Australia and New Zealand	Late 70s-Early 80s	12 000-18 000	0.1-0.1%	Under 100
Caribbean	Late 70s-80s	350 000-590 000	1.9%-3.1%	30 000-50 000
<b>Total</b>		40 (34-46 million)	1.1% (0.9-1.3%)	3 (2.5-3.5 million)

- ≈ # The ranges around the estimates in this table define the boundaries within which the actual numbers lie, based on the best available information. These ranges are more precise than those of previous years, and work is underway to increase even further the precision of the estimate that was published mid-2004.
- ≈ Adults in this report are defined as men and women aged 15-49 and children refers to the group 0-14 years. This age range captures those in their most sexually active years. While the risk of HIV infection continues beyond the age of 50, the vast majority of people with substantial risk behaviour are likely to have become infected by this age. Since population structures differ greatly from one country to another, especially for children and the upper adult ages, the restriction of 'adults' to 15-49 has the advantage of making different populations more comparable.

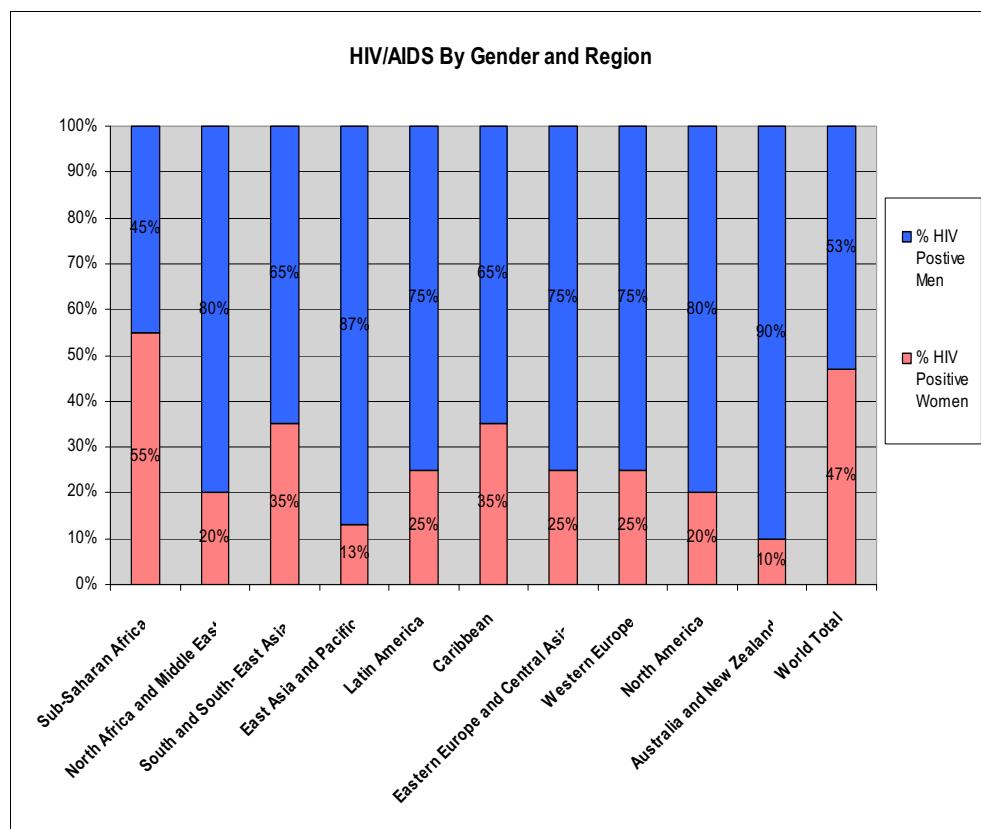
These figures can be represented graphically as follows:



(Source: [http://www.princeton.edu/~ina/thematic\\_presentations/10-12](http://www.princeton.edu/~ina/thematic_presentations/10-12))



(Source: [http://www.princeton.edu/~ina/thematic\\_presentations/10-12](http://www.princeton.edu/~ina/thematic_presentations/10-12))



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HIV/AIDS struck very hard in poor countries as reflected above (Sub-Saharan Africa and South and East Asia): 96 percent of infected people are in the developing world, and 70 percent are in Sub-Saharan Africa alone (World Bank 2002 Online). According to the study by Globe Africa, by the end of 2002 an estimated 42 million people worldwide were living with HIV/AIDS. Over 30 million of them were in Sub-Saharan Africa. The reason<sup>5</sup> for Africa's high statistics is partly that "the virus has been present far longer in the communities of Africa. The virus originated in Africa, and then spread to other continents, as transport became more freely available and travelling became easier" (Christian AIDS Bureau 3.3/1).

*Statistics a complex task:* Statistics provide us with the general picture of what is going on. But one should be aware that statistics are complex and they can

<sup>5</sup> The reasons for Africa's high epidemic shall be discussed in detail in the following sections.

be very misleading, depending on the motive of the researcher and presenter.<sup>6</sup> An example would be that of the Zimbabwean government, which announced a reduction of statistical figures for HIV/AIDS from 33.7% to 27% (UN integrated regional information networks 2004:1). The figure went down further to 24.6% with a range of 20%-28% (Zimbabwe National HIV/AIDS estimates 2003:9). Before the new UNAIDS figure, the Zimbabwean government argued that the high figures presented by UNAIDS were Western propaganda to discredit Zimbabwe and President Mugabe.

An important factor that influences statistics and perceptions is the politicisation of information. Nierkerk (2003:167) in his article, "Mother-to-Child Transmission of HIV/AIDS in Africa: Ethical Problems and Perspectives", discusses political influences on HIV/AIDS, issues focusing on the former adamant position of President Thabo Mbeki that HIV does not cause AIDS, thereby denying antiretroviral drugs to HIV/AIDS-affected people. Nierkerk aptly states, "One of the main complexities facing the management of the disease in Africa, is, therefore, this kind of politicisation of the discourse about AIDS" (see also Makgoba 2001:18; Gumede 2002:36-38; Makgoba 2000:30-31). These political influences make us to treat statistics with suspicion, though without denying that they provide a general picture.

Another important point to note is that in some countries HIV diagnosis and reporting systems are not reliable. Christian AIDS Bureau (4.4/4) notes that:

*Due to under-diagnosis, under-reporting, and reporting delays, surveillance based on cases with clinical manifestations of the acquired immune deficiency syndrome is unreliable in most countries- especially those with weak health care systems.*

It is crucial, therefore, for HIV/AIDS counsellors to remain informed on accurate facts and information, which is always changing. But how does HIV progresses in the body?

## *2.4 HIV/AIDS: Infection and Progress in Africa*

HIV infection progresses through a number of stages until the person eventually dies. However, it is important to explain that these stages are not precisely demarcated into separate and distinct phases with easily identifiable boundaries. It is better to think of the stages as a progression. The stages are: the primary infection phase or acute sero-conversion illness, the asymptomatic latent phase, the minor symptomatic phase, the major symptomatic phase and

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<sup>6</sup> This sentiment was clearly expressed by Afredo Justino (a DTh student at Stellenbosch University) from Mozambique; he indicated that the HIV/AIDS statistics provided by the Mozambican government are likely to be lower than the actual figures. The understatement is designed not to deter investors.

opportunistic diseases, and AIDS-defining conditions: the severe symptomatic phase (Van Dyk 2001:36; Jackson 2002:43; Ray *et al.* 2002:19; and others).

*The primary infection phase or acute sero-conversion illness:* The phase begins at the time of infection when the person contracts the HI virus. After infection a person goes two to six weeks or several months with no signs or symptoms of disease and without detectable antibodies to HIV. An HIV (antibody) test at this time will be negative. This is called the “window period.” Sero-conversion refers to the point when the person’s HIV status converts or changes from being HIV negative to positive (antibody test). This normally occurs after four to eight weeks or more of the window period. The person would have a flu-like illness, fever-like symptoms with sore throat, headache, mild fever, fatigue, rash and oral ulcers. The person may not visit a doctor because the sickness is mild (Shelp and Sunderland 1987:11-13; Grenz and Hoffman 1990: 97-101; Jackson 2002:43; Van Dyk, 2001:36-53).

*The asymptomatic latent phase:* This stage can last from a few months to 10-15 years. The person will not show any signs of infection. The HI virus is present and destroying the immune system, but the person is not aware of this and appears healthy and normal. During this time the person may infect many other people. Jackson calls this stage the incubation period. The only symptom during this stage is persistent generalised lymphadenopathy (PGL) or swollen glands (Jackson 2002:43 and Van Dyk 2001:37; Ray *et al.* 2002:19).

*The minor symptomatic phase:* At this stage the early symptoms of HIV disease usually begin to manifest. Jackson calls this stage “HIV/AIDS-related illnesses”. The immune system is badly depleted and the HIV load has increased greatly. The symptoms include mild to moderate swelling of the lymph nodes in the neck, armpits and groin; occasional fevers; herpes zoster or shingles (which is a sign of low immunity); skin rashes, dermatitis, chronic itchy skin, fungal nail infections; recurrent oral ulcerations; recurrent upper respiratory tract infections; weight loss up to 10% of the person’s usual body weight; and malaise, fatigue and lethargy (Shelp and Sunderland 1987:11-13; Grenz and Hoffman 1990:97-101; Jackson 2002:43; Van Dyk 2001:38).

*The major symptomatic phase and opportunistic infections:* At this stage the opportunistic diseases start to take advantage of the deteriorating immunity. The viral load is very high and the CD4 cells are low. The following symptoms that are signs of immunity deficiency are evident: persistent and recurrent oral and vaginal Candida infections; recurrent herpes infections, such as herpes simplex (cold sores); bacterial skin infections and skin rashes; intermittent or constant unexplained fever that lasts for more than a month; night sweats; persistent and intractable chronic diarrhoea that lasts for over a month; significant and unexplained weight loss (more than 10% of normal body weight); abdominal discomfort; headaches; oral hairy leucoplakia (thickened

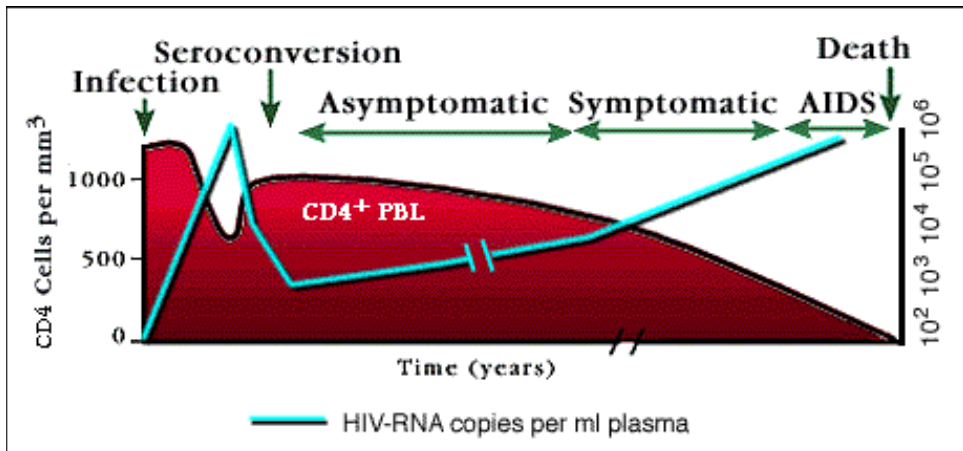
white patches on the side of the tongue); persistent coughing and reactivation of tuberculosis; various opportunistic diseases. At this stage the person is bedridden 50% of the day (Shelp and Sunderland 1987:11-13; Grenz and Hoffman 1990:97-101; Jackson 2002:43; Van Dyk 2001:38).

*The AIDS-defining conditions - the severe symptomatic phase:* At this stage the patient's condition is referred to as "full-blown AIDS" and the body does not respond to antibiotics. These people are confined to their beds and usually die within two years. But in Africa they often die within one year because of the lack of drugs and correct nutrition. The World Health Organisation gave the following guidelines for the diagnosis of AIDS in Africa:

*Major signs: weight loss of more than 10% of body weight; long-lasting diarrhoea; long-lasting fever, i.e. for over a month; major signs - persistent cough, over one month; generalised itchy skin disease; recurring shingles (herpes zoster); thrush in the mouth and throat; long-lasting, spreading and severe cold sores (herpes simplex); long-lasting swollen glands (PGL); loss of memory; loss of intellectual capacity; peripheral nerve damage (Jackson 2002:49).*

The diagrams below (Fig. 2.3 and Fig. 2.4) show the stages of HIV progression in the body (CD4 cells and immunity weakening). In the diagram, both minor symptomatic and major symptomatic are under symptomatic.

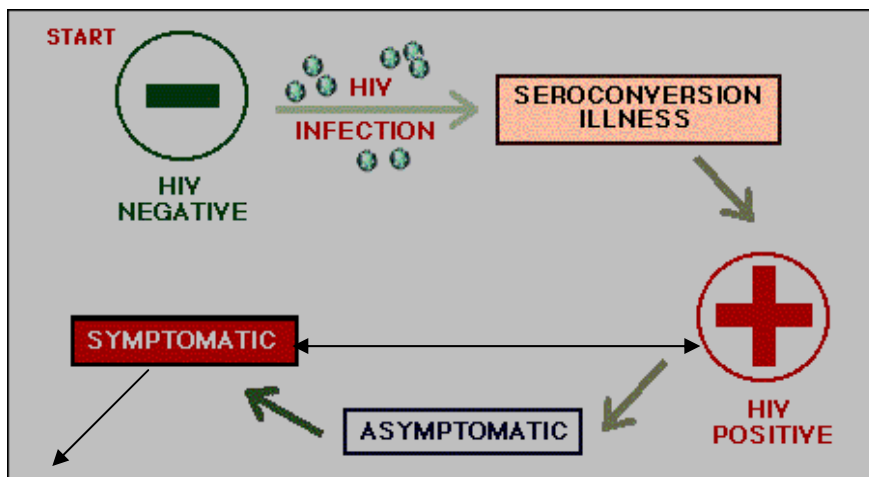
Fig. 2.3: Stages of HIV progression



(Source: [http://www.tthivclinic.com/overview\\_home.htm](http://www.tthivclinic.com/overview_home.htm))



**Fig. 2.4:** Stages of HIV progression (Source: [http://www.tthivclinic.com/overview\\_home.htm](http://www.tthivclinic.com/overview_home.htm))



### AIDS & Death

The progression of HIV diseases varies from person to person and depends on a number of factors including genetics, mode of transmission, attitude to life and adaptation to the HIV status. Though the usual progression is the one denoted by bold arrows, some people jump one stage or return to the previous stage, especially with antiretroviral therapies. However, though the progression takes 8-15 years, in Africa it often takes less than that as a result of poverty.<sup>7</sup> What is clear, though, is that, after seroconversion, each person develops a viral load set point. The lower the viral load, the slower the progression of HIV disease (i.e. immune system destruction) and eventually clinical symptoms and opportunistic conditions leading to death. Knowledge of the five stages discussed is invaluable to people in HIV/AIDS support and care.<sup>8</sup> However, at this point we should ask: what are the factors responsible for the vast extent of the African epidemic?

## 2.5 Factors Influencing the Spread of HIV/AIDS in Africa

The reasons why HIV/AIDS rates are highest in Sub-Saharan Africa are not absolutely clear. But Jackson (2002:8) and others (Shelp and Sunderland 1987:14; Grenz and Hoffman 1990:75-76) identified nine main risk factors for high HIV transmission rates in Southern Africa. These factors are generally the same in sub-Saharan African countries. She outlined them as: population

<sup>7</sup> Discussion on the relationship between HIV/AIDS and poverty is found in Chapter 3.

<sup>8</sup> Discussion of relevant pastoral care response at each level is discussed under HIV/AIDS healing (Chapter 6).

movement, including military movements; developed trade and transport routes; gender inequity and inequality; poverty and unequal distribution of wealth; lack of social cohesion in some areas; multiple partnerships, including commercial sex; various cultural factors (e.g. low rates of male circumcision); high level of untreated sexually transmitted infections and reproductive tract infections; and relatively low condom use (Jackson 2002:8).

Jackson correctly added that these factors enable identification of high-risk environments, and hence population groups likely to be at high risk, and also suggests issues that need to be tackled to reduce risk environments and make them safer. The last two points indicate specific targeted interventions to reduce transmission rates.

Louw (1995:32), in his article "Pastoral Care for the Person with AIDS in an African context", highlights almost similar factors as Greyling's (2003). He states that the most common reasons for the high African HIV/AIDS rates are that:

- ≈ African males are traditionally polygamous, or have several wives or sexual partners. "Also, despite the effect of modern life on tribal customs, polygamy and concubinage are still tacitly accepted as normal cultural practices among Africans. Even if linked to the threat of AIDS, therefore, sexual promiscuity is unlikely to carry a stigma of disapproval" (Mokhobo 1988:34);
- ≈ Migratory labour and continuous movement between rural areas and cities heighten the risk of AIDS spreading;
- ≈ Women's lack of status gives them very little bargaining power in sexual relationships. They have very little chance of insisting that their husbands use condoms. "Many blacks perceive contraceptive advice as a political manoeuvre supporting White engineered intentions (1988:34);
- ≈ Women's lack of economic power contributes to increased prostitution. So, for example, the second virus, known as HIV-2, was discovered in 1985 among prostitutes in Senegal. The virus is transmitted mainly through heterosexual activities. Therefore the research of Hoffman and Grenz (1990:93-94) reaches the conclusion: "HIV in Africa is predominantly a heterosexually transmitted disease, the main factor being the degree of sexual promiscuity rather than sexual orientation (as in the United States)";
- ≈ Fertility in some groups leads to continuous procreation by AIDS-infected parents;
- ≈ The high incidence of sexual diseases enhances the spreading of AIDS;
- ≈ AIDS is rapidly increasing among children in South Africa;
- ≈ AIDS programmes providing information, also on prevention, often do not reach those groups in the highest risk factor. Many people are illiterate, while ignorance and carelessness also play an important role (Louw 1995:32).

The reasons outlined by Louw, like those of Jackson and many other writers, emphasise that the African HIV/AIDS scenario is, in a way, the consequence of sexual carelessness and irresponsibility, apart from the children infected through rape and PTCT. One could add disinformation, and lack of information and education to these reasons. The carelessness and irresponsibility manifest in promiscuity and other high-risk sexual practices. The factors responsible for the African scenario, therefore, may be classified as macro, socio-economic, sexual behaviour and biomedical (Barnett and Whiteside 2002:78).

Macro factors include governance and structures that promote the wealth of the country and income distribution, and the culture of the people (i.e. cultural practices that may fan the epidemic).<sup>9</sup> Socio-economic factors include migration, mobility, urbanisation, access to health care and women's low status. Sexual behaviour includes rate of partner change, concurrent partners, abuse of power, sexual practices, and ethics – norms and values.<sup>10</sup> Biomedical factors include virus subtype, i.e. HIV-1 found in many African countries is highly virulent, and the presence of other STDs due to poor access to medical care, which increases the risk of infection. But it is important to note that these factors are intertwined. Furthermore, in many cases they are circumstantial, i.e. they are driven by poverty (as described in Chapter 3).

However, the factors indicated above, which reflects many writers' thoughts, do not fully explain the African epidemic. Katz (2000) rightly comments that individual behaviour (which is often the focus of the above factors) alone cannot possibly account for the enormous variation (see statistics) in HIV/AIDS prevalence between population groups, countries and regions, and that the unexplained remaining variation has been neglected by the international AIDS community. For instance, in the West economies are stronger and population movements are greater than Africa, especially the poor sub-Saharan region. Even considering trade and transport routes, Western countries are advanced. There is also high migration in the West, e.g. from Eastern Europe to Western Europe and also USA, because of the pull of the stronger economies. And considering gender inequity and inequality, poverty and unequal distribution of wealth, Arabs (Muslims) are in a worse situation. Women are considered as having lower status and yet HIV/AIDS cases are very low (as low as 0.2%).

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<sup>9</sup> Brown (2004:113-135), focusing on the Malawian *Chewa* culture, and Jackson (2002:134-138), who focuses on the Zimbabwean context, concur that some of the uniquely African practices of Sub-Sahara Africans are related. They are: village night dances, weddings and funerals, initiation practices, *gowelo* (teenager's moving from sharing the house with parents into their detached houses), *chisuweni* (considering cousins offspring of the parents as spouses), sitting in husband (when the husband is impotent), polygamy, *chokolo* (young brother taking over the wife of the deceased), gender issues (women subservient), poverty (compelling women into prostitution) and denial.

<sup>10</sup> The effect that these factors have on HIV/AIDS in Africa is delineated in Chapter 3, i.e. interplay between poverty and HIV/AIDS.

Therefore, this shows that the factors causing HIV/AIDS are complex and not easy to fully pin down.

Statistics show that the highest HIV/AIDS rates globally result from sexual encounters. And there is general global moral decay. The example could be London, but this is likely to be the case in many Western countries. The newspaper the *Daily Mail* (October 29, 2003, pp. 40-41), has a story entitled "The teenage sex epidemic: The infertility time bomb". The story describes high levels of promiscuity among London teenagers and young adults.

They delay cohabiting and avoiding commitment, while they involve themselves intensively in sexual activities. Many of them, i.e. one in seven under-16s, get infected with the sexual infection chlamydia that later causes infertility. The report states that Natalie Clarke, who is the victim of the sexual infection:

*[S]tarted having sex at 13. At age 25 she began trying desperately for a baby - but without success. The cause of her infertility? Chlamydia, one of a number of sexually transmitted diseases whose incidence has soared with rising teenage promiscuity (London daily Mail 2003).*

The story is confirmed by the victim's own testimony: "I started having sex at 13 when I met my first boyfriend...Sex was all anyone seemed to talk about at school and there was lots of pressure to do it" (page 40). The story expresses desperation and fear in the London community, since it threatens to reduce the population significantly in the near future. And it underscores two crucial risk behaviours that fan the HIV/AIDS epidemic, i.e. promiscuity and unsafe sex. Statistically Western Europe has 3% HIV/AIDS cases, while Sub-Saharan Africa has 70%. Therefore, we may ask: why then does Africa have the highest number of HIV/AIDS cases?

There are certainly factors that fan the spread of HIV/AIDS in Africa. But what are they precisely? HIV/AIDS counsellors and awareness programmes should desist from working on sketchy and unjustified facts. Sometimes the factors that are targeted are the wrong ones. The Nelson Mandela HSRC (2002:15) (NHM) report, which is the first comprehensive HIV/AIDS research in South Africa, states

*Various socio-cultural practices such as polygamy, dry sex, anal sex, rites of death of spouse for widows, and consultation with traditional and alternative healers...which, according to the literature review are believed to be widespread in South Africa, were found to be uncommon.*

This discovery warns counsellors, caregivers and programme planners to avoid focusing on the wrong areas. Thus Katz (2002) warns that this focus on individual behaviours has often neglected the root causes of the African

HIV/AIDS rates. Thorough investigation should always be undertaken. The NMH report, however, revealed that:

*The majority of respondents indicated that they needed further information about the disease, including additional information in relation to sexual abuse, condom regulation, STIs, blood transfusion, VCT, counselling, HIV/AIDS symptoms and treatment, caring for people living with HIV/AIDS, and rights (2002:17).*

The context in which care and counselling and awareness programmes are to be implemented should always determine the content. Transplanting facts from one context to another, and reliance on presuppositional and untested theoretical assumptions, should be avoided.

Nevertheless, though the factors summarised above may not fully account for the spread of HIV/AIDS in Sub-Saharan Africa, they remain key to the spread of HIV/AIDS. But we have reason to think that there are other complementary factors.

In summary, Hunter's (2001:12) explanation together with the above factors may probably shed more light to the discussion. She wrote:

*A number of factors are at work in determining HIV prevalence, including factors particular to the HIV-1 virus itself and factors in the human environment in which it finds itself. There is some support for the theory that different clades, or genetic subtypes, of HIV-1 are less virulent<sup>11</sup> than others. The predominant subtype in Uganda may not be as virulent as those found in other countries. Clad B, associated with epidemics in the Northern Hemisphere, may be less virulent than all clades found in developing countries.*

In addition, Greyling and Murray (2004) states:

*Part of the reason why HIV statistics are so high in Africa is that the virus has been present far longer in the communities of Africa. The virus originated in Africa, and then spread to other continents, as transport became more freely available and travelling became easier. This is only part of the reason, as infrastructure, migrant labour, poverty, culture, etc., also play a major role in the extent of the spread of the virus.*

Therefore, Hunter's explanation of different clades and genotypes, i.e. "some researchers hypothesise that African clades are more virulent" (Hunter

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<sup>11</sup> Virulence is the power of a virus or bacteria to cause a disease, measured by the number of people it affects, how easily infections occur, how quickly the virus spreads through the body, and how quickly the disease progresses to death.

2001:34), the Christian AIDS Bureau's issue of history (origin) and length of HIV presence on the continent, coupled with environmental factors noted by Jackson,<sup>12</sup> Louw and many others, may provide the best comprehensive and convincing explanations for Africa's high HIV/AIDS rates. Otherwise, apart from low levels of poverty,<sup>13</sup> there could arguably be no satisfying explanation why HIV/AIDS cases are low in the West.

However, having considered the factual aspects of HIV/AIDS, it is important to consider how African<sup>14</sup> people perceive it. Thus the question: how does HIV/AIDS fit into the African worldview (framework) of sickness? For a list of questions and answers regarding HIV/AIDS visit: <http://www.avert.org/aids-africa-questions-1.htm>

## *2.6 HIV/AIDS within the African Scenario: Sickness in this Worldview, and Perceptions Regarding HIV/AIDS*

**Culture and worldview:** Culture is the "super-glue that binds people together and gives them a sense of identity and continuity, which is almost impenetrable" (Kwast 1981:362). It can be depicted as a concentric circle with behaviour on the outer layer and worldview at the centre. Hesselgrave (1991:197) likened worldview to coloured glasses through which people see themselves and the universe around them. Everything is given the 'tint' or 'hue' of whatever particular worldview spectacles the person happens to be wearing. Moreover, since the vast majority of people are used to just one pair of spectacles from the time of their earliest recollections, they are not predisposed – even were they able – to lay them aside (even temporarily) in order to look at the world through another pair of spectacles. A worldview, therefore, is the way people see or perceive the world, the way they know it to be. It is a person's idea of the universe. Michael Kearney's definition cited by Hesselgrave (1991:198) aptly sums the meaning of worldview: "The worldview of a people is their way of looking at reality. It consists of basic *assumptions and images* that provide a more or less coherent, *though not necessarily accurate*, way of thinking about the world" [my emphasis].

Understanding worldview as the core of every culture explains the confusion that some people have at the level of beliefs. One's worldview provides a

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<sup>12</sup> Population movement, including the military; developed trade and transport routes; gender inequity and inequality; poverty and unequal distribution of wealth; lack of social cohesion in some areas; broad sexual mixing and multiple partnerships, including commercial sex; various cultural factors (e.g. low rates of male circumcision); high level of untreated sexually transmitted infections and reproductive tract infections; and relatively low condom use.

<sup>13</sup> Detailed discussion on the relationship between poverty and HIV/AIDS is the focus of Chapter 3.

<sup>14</sup> African in this section refers to black indigenous Africans who hold onto supernatural cause and effect worldviews on sickness.

system of beliefs, which are reflected in one's actual values and behaviour. Sometimes a new or competing system of beliefs is introduced, like Christianity (to African culture), but the worldview remains unchallenged and unchanged, so values and behaviour reflect the old belief system. This scenario has caused much disappointment to many missionaries and Christians in Africa. They fail to break through the roots of African values and beliefs, e.g. their perception of sickness and suffering, including HIV/AIDS. People's worldview provides reason, interpretation, meaning, explanations, relations to others, adapting to or making decisions with regards to issues of sickness, HIV/AIDS, nature, death, or God (Kraft 1999). Therefore we can pose the following questions: How do African people perceive sickness? How does HIV/AIDS fit into this conceptual framework?

***African view of sickness and HIV/AIDS:*** Berinyuu (1988:49-50) in *Pastoral Care to the Sick in Africa* agrees with Forster's analysis of the African notion of sickness, namely that it is personalistic. A personalistic medical system, as mentioned earlier, is one in which disease is explained as being due to the active purposeful intervention of an agent, who may be human (a witch or sorcerer), non-human (a ghost, an ancestor, an evil spirit), or supernatural (a deity or other very powerful being). The sick person is viewed as a victim, the object of aggression or punishment directed specifically against him or her. This view of sickness is in contrast to the Western naturalistic system that explains sickness in impersonal terms, systemic terms. Disease is thought to stem, not from the machinations of an angry being, but rather from such natural forces or conditions as cold, or an upset in the balance of basic body elements. Thus, supernatural causes are perceived as the causes of sickness in Africa, while in the West it is caused by non-supernatural causes.

Mwaura's (2000:72-119) article in *Pastoral Care in African Christianity* underscores this: illness (sickness) is "often attributed to breaking of taboos, offending God and/or ancestral spirits; witchcraft, sorcery, evil eye passion by an evil spirit and a curse from parents or from an offended neighbour" (2000:79). Ncube (2003:108) emphasised that this thinking has so great a command in people's lives that it would not be wise to ignore it. The Zulus' (South Africa) traditional way of coping and dealing with *ukugula* (sickness) may be representative of many Sub-Saharan African peoples' response:

*Many Zulus' illnesses are deliberately caused by enemies (izitha) or ancestral anger (ulaka lwabaphansi/abadala) because of jealousy (umona) or neglect (ubudedengu) by family members. Hence the efficacy of the medicine is made possible by studying correctly one's surroundings and taking proper cautions (Ncube 2003:108).*

However, how do these supernatural forces cause sickness?

- ♻ *Witchcraft and sorcery:* Witches are normally human beings who are still alive and who possess magical substances and can utter curses to their enemies. They are also believed to be vehicles of dangerous mystical powers and practise antisocial magic. Hence, they cast spirits or spells on other people.
- ♻ *Ancestors:* Ancestors are benevolent spirits who preserve the honour and traditions of a tribe and people, family and individual against evil and destructive forces. Ancestors, however, can punish people by sending illness and misfortune, if people do not listen to their wise counsel, if certain social norms and taboos are violated, and if culturally prescribed practices and rites are neglected or incorrectly performed (Van Dyk 2001:112). Secondly, ancestors may not necessarily cause sickness but, since they have a protective function, if they are angered they may withdraw protection, leaving the person exposed to attack by witches or any pathogens.
- ♻ *Curses:* In many instances a curse from parents and disobedience to parents cause misfortune and vulnerability. Parents should always be consulted for guidance, wisdom and blessing.
- ♻ *Nature Spirits:* When shrine spirits do not get sacrifices, they can also cause sickness, or send pests and uncommon diseases, such as AIDS, to people.

Mwaura (2000:78), Berinyuu (1988:6ff), Kasambala (2004:97), Mbiti (1975) and many other African writers concur that health (being free from sickness) in Africa produces equilibrium. Africans generally believe that human beings are in a state of complete dependence upon the invisible powers and beings. Health is a sign of a correct relationship between the person and the supernatural world and breaking from the delicate balance can cause misfortune and sickness. Kasambala aptly sums it up thus:

*One could not possibly fall sick unless there is a disturbance within the systematic rhythm of life, which includes: the breakdown of harmony in personal and communal relationship, disrespect for cosmic existence within the cosmology of an African spirituality and/or lack of adherence to African traditional health values (2004:97).*

However, apart from the witch and sorcerer, who have predominantly negative associations, all the other causes of sickness result from breaking the equilibrium, which means one brings upon him/herself sickness by breaking the balance. Therefore, when people are sick they consult diviners and *Sangomas (N'anga)*, who in turn advise them on the right sacrifices and initiations to appease the ancestors or sprits, thereby restoring the balance.



The personalistic view of sickness and suffering does not negate or diminish the naturalistic causes of sickness, such as germs, viruses or bacteria. Mwaura (2000:70) comments: "Though most Africans are aware that some illness has natural or organic causes, there is still an overriding belief in the supernatural or spiritual causation of illness". Therefore in seeking a cure, one does not only rely on medication (herbs, injections and tablets), but also includes mystical and spiritual remedies. How then does HIV/AIDS fit into this supernatural framework?

HIV is the virus responsible for causing AIDS. This explanation is naturalistically correct. How, then, is it perceived personalistically/supernaturally? Van Dyk (2001:114) cites Yamba's 1997 study report on HIV/AIDS in many African countries which revealed that, especially among the rural poor or least educated, they believe that HIV transmission, AIDS and deaths are caused by witchcraft. However, with the growth of HIV/AIDS awareness, many people are starting to embrace the naturalistic explanation (though within a personalistic framework) (see Nelson Mandela/HSRC report 2002). Many African people agree that witchcraft or the ancestors do not directly cause HIV, but they are always associated. For instance:

- ≈ A jealous relative may cast a spell on a successful young professional that blinds him/her, leading to unsafe sex with an HIV-infected partner;
- ≈ The ancestors may also be angry with a young successful professional who forsook them and broke the taboos. Hence, they withdrew protection, leaving him/her vulnerable by having sex with an HIV-infected partner. Besides, they may also direct him/her to have sex with an HIV-infected person so that he/she may learn to conform to the balance.

Therefore, though HIV may be ultimately responsible for causing AIDS, there is always a supernatural link. More than 25% of people in Yamba's study in Zambia asked a question that clearly reflects this thinking: "Why will one man become infected and the other remain uninfected when both have had sex with the same woman?" (Van Dyk 2001:114).

The association of HIV/AIDS with supernatural causes has a strong psychological function. If one blames external factors such as witches or sorcerers for AIDS, it removes the responsibility from the HIV victim, family and society. In addition, this hypothesis fits well as a comprehensive explanation within the African worldview of sickness, thereby removing feelings of guilt and anxiety. The witchcraft beliefs also resolve the community's need to explain why some people who are at risk do not contract HIV/AIDS. Furthermore, due to the stigmatisation associated with HIV, attributing HIV/AIDS to witchcraft helps the family not to be stigmatised by the community. Ncube (2003:103 citing Aylward 1973) aptly sums this up by saying that accusing a witch "provides a way to explain serious misfortunes

and to render those who suffer them blameless in the eyes of society. Putting the blame on the witch is a method of exculpation<sup>15</sup> of self”.

However, attributing HIV to supernatural causes has negative implications. The belief that everything is caused by external, supernatural beings implies that individuals may not be held responsible and accountable for their own behaviour. HIV calls for responsible sexuality. Besides, this attitude needs to be changed in the case of HIV/AIDS, since it is the (extended) family members that are most often accused of witchcraft and sorcery.

Many African writers share the idea that the African worldview should be taken seriously if one is to minister to them successfully (i.e. provide pastoral care). The argument is that the perception that sickness is caused or always linked to supernatural causes should be taken as central. Mbiti's (1975:3) assertion is insightful:

*Unless Christianity fully occupies the whole person as much as, if not more than, traditional religions do, most converts will continue to revert to their old beliefs and practices for perhaps six days a week, and certainly in times of crisis and emergency.*

This is often the case regardless of education and upbringing, though this varies. Hammond-Tooke's (1989:23) research on perceptions of the causes of sickness in an African context revealed that 8% of rural and 7% of urban people believed that sickness was caused by witchcraft. This shows that there is little difference in perception between the urban and rural Africans. It is crucial, therefore, to underline that people's worldview, though it may appear primitive and irrational, is the key to their understanding and interpretation of the world and cannot easily be abandoned. Thus for Africans, any sickness, HIV/AIDS or crisis is always linked to supernatural causes.

The African understanding of HIV/AIDS and other sicknesses has to be treated with due care and precision in order to successfully understand the undergirding values and beliefs. Brown (2004:108), who is an American, stated after her doctoral empirical research on HIV/AIDS issues in Malawi:

*It is often difficult to fully understand the depth of these customs and cultures in the tribal peoples of Africa. Although they are diminishing in their grip on the individuals who have broken free of the traditional village setting and have moved into the urban areas where many people of differing practices live in close proximity to one another, even in these city dwellers the culture affects the fibre of their being.*

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<sup>15</sup> To exculpate is to free someone from blame.

*African customs and traditions do not only play a major part in the formation and development of a child as he or she grows into childhood, they also make up the very character of the world view that individual will develop, which colours the understanding that person will have about aspects of life. A person cannot divorce himself from cultural heritage without destroying a major portion of his identity as an individual.*

This understanding, which could apply generally in Sub-Saharan Africa, can easily be perceived when one spends time speaking to African Christians in general. There are often undertones of an African culture and Christian mix in core existential questions about suffering, as in that associated with HIV/AIDS.

Africa is experiencing a serious crisis – Jackson (2002) rightly entitled her book *AIDS Africa – Continent in Crisis*. HIV/AIDS is severely affecting both the urban and the rural areas and the close link between cities and rural villages fans the spread of the disease. Many Africans who have two homes exacerbate this situation. The city home is where they live while working, and at the month end or vacation they return to the village. Joda Mbewe's article in *Studying Congregations in Africa* (Hendriks 2004:121) made this point very clear. With reference to Malawi, he wrote:

*Urban Africans have very strong ties with their traditional rural culture. Malawians, who live in urban centres, commute to their rural homes for marriages, planting and harvesting crops, building houses.*

Apart from fanning the spread of AIDS, this link creates people who are in “two semi-encapsulated worlds,” as Mbewe described them. But this researcher prefers to call it “culture-mix confusion”. In the cities they accept foreign ideas and norms, while in the villages they adhere to their traditional values. Consequently, they lose their African roots and at the same time they are far from Westernised, i.e. “culture confusion”.

The African cultural practices should be understood well in order to have meaningful intervention. Brown (2004:113-135), focusing on the Malawian Chewa culture, and Jackson (2002:134-138) on the Zimbabwean context, concur that some of the uniquely African practices of Sub-Saharan Africans are usually the same. They are: village night dances, weddings and funerals, initiation practices, *gowelo* (teenager's moving from sharing the house with parents into their detached houses), *chisuweni* (considering cousins- offspring of the parents as spouses), sitting in husband (when the husband is impotent), polygamy, *chokolo* (young brother taking over the wife of the deceased), gender issues (women subservient), poverty (that is compelling women into prostitution) and denial.

However, though the practices that Brown and Jackson identified may have been supported and justified by research (Brown) and experience (Jackson), they probably indicate outdated practices that no longer prevail among the African majority. With the influence of Christianity in many rural areas, most of these practices have died out. Besides, there are higher HIV/AIDS rates in the urban centres, where these practices are vestigial as a result of education and exposure to Western culture (see NMH 2002:21). Hence, to attribute the African HIV/AIDS scenario to these factors may not be justified.

Furthermore, Brown's empirical research is flawed. It does not adequately control for research validity, hence the results are not very credible. As a researcher and lecturer, she has to be aware that respondents (and especially one's students) give responses that they think you are looking for. Her claim of factual accuracy by saying that

*The integrity of these students as they presented this material (i.e. research feedback) is not under any suspicion as they were under no pressure to provide information, which might have caused them to embellish or exaggerate the claims in their reports (in other words, there was no promise or insinuation made that their grade or acceptance would be in any way affected by the content of the traditions described) (Brown 2004:110).*

This shows her limitations in understanding African students. They have read books on HIV/AIDS and they know what she was probably looking for. It is normal and polite for African students to provide the correct answers. It is very unlikely that they would provide different answers to what is widely accepted (i.e. what they read in books). Often what is written (especially from the West) is the truth that they will follow. In any case, Brown herself concurs with this reasoning, as she rightly notes in one of the concluding statements:

*Many of the customs described in this chapter are diminishing; some to the point where they are practised only in the most remote areas where the Christian and Western influences have had the least amount of impact. Other practices are being re-evaluated, and if not discarded completely they are being revamped and restructured in such a way as to keep the rich cultural aspects and purposes, with revisions designed to eliminate the dangerous practices which have been associated with them (2004:134).*

An example of revamping and restructuring she cites is that of female initiation, where the churches have undertaken to look for ways to retain the foundational messages that have been valued in this important cultural practice. The women leaders in the church may assume this role rather than the original non-Christian women.

Another typical example of restructuring in South Africa has to do with male circumcision. Due to the danger and vulnerability to HIV/AIDS, the government has intervened by providing safe ways of doing the surgery.

However, of the practices mentioned by Brown, denial poses an enormous threat to making successful inroads towards creating HIV/AIDS care and awareness. This researcher and Sean Kampondeni (participants in Brown's research) agree that

*A lot of people believe that AIDS is not real. They argue this from the fact that their ancestors and forefathers never knew it. They do believe that it must be a certain form of infection that has come into effect because there is moral decay and that people have abandoned the worship of ancestors. Some have boldly professed that this disease does not exist (Brown 2004:129).*

This understanding/worldview can have serious negative implications when it comes to attitude change. The idea of ascribing HIV/AIDS to witchcraft leading to such denial may lead to a refusal to take preventative and protective measures, thereby infecting many other people. However, one has to realise that if one wants to work with a particular people, understanding their worldview is not an option, but a necessity. HIV/AIDS education and counselling have to take cognisance of African culture. For instance, diagnosis and analysis should explore the strength of African traditional beliefs, influences and practices in order to apply effective therapy. But, certainly, negative aspects like denial should be suppressed.

## 2.7 Summary and Conclusion

The core arguments and conclusion drawn from this chapter are that:

- ☞ The Church in Africa is strategically located. In fact, in many poor communities the church is one of the few key structured community institutions. Research has shown that the church is more effective in information dissemination than other HIV/AIDS organisations. Therefore, it should play a central role in this regard, which entails equipping church people who are the caregivers with adequate information;
- ☞ The church people who are the pastoral caregivers should have accurate HIV/AIDS information on the definition and description, origin, infection, transmission and statistics in order to offer effective and informed care.

*HIV/AIDS definition and description:* The difference between HIV and AIDS should be emphasised. HIV is the virus that will eventually lead to AIDS. AIDS is a condition in which the body is susceptible to any infection, since it can't defend itself. From HIV infection to full-blown AIDS can take 10-15

years or even longer, depending on the attitude that the person adopts and the availability of antiretroviral drugs. Therefore, pastoral care should emphasise that being diagnosed HIV positive does not mean that you will die tomorrow. There is still life beyond infection.

*Origin:* There are some speculative theories regarding the origin of HIV, but there is scientific evidence that HIV-1, which is more virulent and widely spread throughout the world, originated from a chimpanzee. A particular kind of chimpanzee is known to carry a virus quite similar in structure to HIV. HIV-2 is less virulent and found in West Africa; it originated from the sooty mangaby monkey.

*Infection, transmission and statistics:* HIV is passed on from an infected person to the next through unprotected sexual encounters (86%), through blood transfusion (<1%), and mother to child (13%). When the HI virus enters the body, it attaches itself to the CD4 cells (i.e. special type of white blood cells) and multiplies. The body's immune system declines, since the defence system is being destroyed. When the CD4 cells are less than 200 per millilitre of blood the person is diagnosed as having AIDS. In this condition the body can't defend itself and is open to any invasion, hence the person may die from any disease. When the HI virus enters the body, it progresses through various stages, but the process may be accelerated by poverty and a negative attitude to life.

Africa, especially Sub-Saharan Africa, accounts for 70% of the HIV/AIDS cases in the world. The reasons for the high figure are partly that HIV has been around in Africa for a longer time (since it originated in Africa), the HIV clades found in Africa are more virulent, and some other factors such as population movement, including military movements; developed trade and transport routes; gender inequity and inequality; poverty and unequal distribution of wealth; lack of social cohesion in some areas; multiple partnerships, including commercial sex; various cultural factors (e.g. low rates of male circumcision); high levels of untreated sexually transmitted infections and reproductive tract infections; and relatively low condom use.

- ~ Within the African worldview, sickness is perceived to be personalistically/supernaturally caused. The witches, ancestors, breaking taboos, curses or nature spirits cause it. Human beings are in a continuous relationship with cosmic forces, which influences them. Angry spirits may cause someone to be sick and sacrifices may restore the cosmic balance. Therefore, breaking away from this delicate balance in Africa is risky and it warrants supernatural sanction.

Hence within the African conceptual framework, though AIDS may be attributed to a naturalistic cause (HIV), there is always a supernatural link.

Thus the supernatural forces cause the individual to engage, in one way or another, with an HIV-infected person. Therefore, though there may be no outright denial of a naturalistic cause, the supernatural force is the overriding cause that influences the infection.

The African perception of HIV/AIDS has a psychological function. The affected people are considered innocent but victims of angry supernatural forces. The community, therefore, views them as people deserving assistance. However, this interpretation has negative implications for people's sexual behaviour. People may not be held responsible. Pastoral care, therefore, should be aware of the African worldview when erecting support systems.

The foregoing discussion of an African contextual understanding of HIV/AIDS attempted to highlight basic HIV/AIDS information in the light of the African context. The assumption of the chapter is that HIV/AIDS information (naturalistic explanation) on its own to pastoral caregivers and counsellors may not address the core difficulties, anxiety and despair associated with coping with the HIV/AIDS situation among African peoples. Therefore, understanding the African worldview would allow pastoral care to further focus on deep complexities underlying the affected people rather than focusing on superficialities. One such complex feature underlying the African epidemic is the intricate link with African poverty. Hence pastoral care, apart from focusing on HIV/AIDS information and an African worldview, should unravel the poverty-HIV/AIDS link for it to be relevant. The following question, which introduces us to the next chapter, can therefore be posed: what is the relationship of HIV/AIDS with poverty in Africa?

# *III. The Interplay between HIV/AIDS and Poverty in Africa*

## *3.1 Introduction*

If poverty and HIV/AIDS were brands, African countries, especially the Sub-Saharan countries, could have solved their economic dilemma. Not only because these two issues are mostly associated with Africa, but the African leaders would be among the greatest world marketers. Rarely does one hear government officials' speeches when these two matters are not mentioned as focal issues. Indeed they are huge threats to African hopes. But do these officials understand what poverty is? What about the general majority? Poverty: is it one-dimensional or multifaceted?

Chapter 2 gave an overview of HIV/AIDS information and the issues related to the pandemic in Africa. This chapter attempts to unravel the intricate nature of the poverty-HIV/AIDS relationship in Africa. The chapter, therefore, attempts to address the issue of the interplay between HIV/AIDS and poverty in Africa. However, before embarking on a detailed discussion of the relationship between HIV/AIDS and poverty, there should be a working understanding of what poverty means (see 3.2). Secondly, since our focus is on pastoral care, which is a theological enterprise, it is pertinent also to briefly explore the biblical meaning of poverty (see 3.3). Hopefully, in so doing, the Church would



seriously and critically reflect on its role of mediating God's Kingdom<sup>1</sup> in situations where people are caught up in the HIV/AIDS and poverty web. The Church, then, asks a critical question: what does it mean to be Christ's disciple in the context of poverty and HIV/AIDS?

Therefore, to start the discussion, the following basic questions are posed. What is poverty? What is the biblical meaning of poverty? But the central question remains: what is the nature of the interplay of poverty and HIV/AIDS in Africa?

### *3.2 Poverty: Definition and Description*

Poverty is a difficult term to define clearly. It is relative, though the World Bank and many other international organisations attach to it a clear and concise definition. In fact, the Word Bank recognises that poverty is relative, but the definition is a yardstick for them to determine the countries that require aid.

The *Oxford Advanced Learner's Dictionary* (2000:910) simply defines poverty as "the state of being poor". From this definition one still needs to define "poor" in order to have a clear understanding. In a simplified way again the dictionary (2001) defines "poor" as having very little money or not having money for basic needs. However, restricting poverty to money as the definition does is not informative enough. What about material assets? This definition accommodates assets, since they can be converted to cash to purchase goods. But this definition can be extended further: what are needs and who determines them? For instance, does a bushman need a house?

Pieterse (2001:30), citing May and Govendor's definition, states that "poverty is the inability of the individuals, households, or entire communities, to command sufficient resources to satisfy a socially acceptable minimum standard of living". This definition underscores the same idea as the Word Bank that poverty is the inability to attain a minimal standard of living.<sup>2</sup> However, this understanding of poverty also does not state who determines the living standard for the people. Could someone from New York or London say that the people in Umtata are poor because they cannot afford a Mercedes Benz?

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<sup>1</sup> The Kingdom of God refers to the rule of God. Grudem (1994:864) rightly clarifies this by explaining that the kingdom manifests itself through the church, and thereby the future reign of God breaks into the present (it is already here: Matt. 12:28; Rom 14:17 - and not yet here fully: Matt. 25:34; 1Cor 6:9-10). Those in Christ begin to experience something of what God's final kingdom will be like and Christians share the concerns of the king about the world, e.g. care and love to the broken, the distressed and the poor, and all those affected by HIV/AIDS.

<sup>2</sup> The discussion on living standards follows below.

Therefore the World Bank 2004 (Online), in attempting to clearly define poverty, outlined some descriptive aspects that embrace the various facets of poverty. Thus:

*Poverty is hunger. Poverty is lack of shelter. Poverty is being sick and not being able to see a doctor. Poverty is not being able to go to school and not knowing how to read. Poverty is not having a job, is fear of the future, living one day at a time. Poverty is losing a child to illness brought about by unclean water. Poverty is powerlessness, lack of representation and freedom.*

The above description of the various aspects of poverty clarifies it. The description captures the person's context and experience. In that sense, then, poverty is contextual and experiential, which is consistent with its relative nature. Pieterse (2001:30) offers a guideline for understanding poverty that also echoes poverty's experiential nature in agreement with the World Bank's description. He wisely states that "what poverty means is the poor's own experience". He went further to apply the experiential dimension of poverty to the South African context when he says that to a South African poverty means not knowing where the next meal is coming from, or fearing eviction from their meagre dwellings because they cannot pay the basic rental. There is also fear that the breadwinner will lose his job (Pieterse 2001:30).

Myers (1991:580), in his article "What is Poverty Anyway?", introduced a spiritual and relational dimension to poverty. He argues that we should move beyond understanding poverty as the absence of things and knowledge. The heart of poverty, he argues, is a spiritual issue and relationships that don't work, as well as power that is misused. Thus Myers adopts a biblical approach to understanding poverty, which will be discussed in the next section (3.3).

However, though poverty is experiential and contextual, as Pieterse and other writers rightly argue, it is important to develop indicators to determine it, otherwise donors won't be able to fund poverty-alleviation projects. Therefore, focusing on the objective aspects of poverty, Burkey (1993:4) described it in concrete and measurable terms. He defined it in terms of basic needs, which are those things that an individual must have in order to survive as a human being. These needs include clean air and water, adequate and balanced food, physical and emotional security, physical and mental rest, and culturally and climatically appropriate clothing and shelter (1993:3). Burkey further says that the human race does not depend on the survival of a single individual, but on the survival of communities; hence the individual needs should include those of the community. These community needs are defined as: sexual regeneration, a system of communication, a belief and educational system for cultural continuity, physical and cultural security, a political system defining leadership

and decision-making, and systems of health and recreation for maintaining the well being of sufficient numbers to maintain the community.

In *A Curriculum for Community Development in Practical Theology* August (1999:14) sheds more light in defining poverty. He agrees with Burkey that poverty is defined in several ways. Poverty can refer to case poverty, community poverty, absolute poverty and relative poverty. *Relative poverty* refers to people whose basic needs are met, but who still experience some disadvantages regarding their social environment. *Absolute poverty* refers to the inability of an individual, community or nation to meet its basic needs satisfactorily (Burkey 1993:3-4; August 1999:14-15; Grigg 1991:583). *Community poverty* refers to a situation where almost all are poor and where more affluent people are more visible to the rest of the people living close to them, as seen commonly in rural areas. *Case poverty* is found in affluent societies, where individuals in a family suffer and where individuals do not share in the general well being of society (August 1999:14).

Another important feature of poverty to note is that first and third world poverty are different. Grigg's (1991:584) article, "The Urban Poor: Who are we?" contrasts the features of first and third world poverty. His central focus in the contrast is that poverty in the first world is usually relative and respective governments address it through welfare, while in the third world the poor actually struggle to get their daily food. Grigg's assertion makes the case for the experiential and contextual nature of poverty stronger. However, in the case of HIV/AIDS home-based care in Africa, poverty refers to community poverty as well as attitudinal poverty. This may also entail being functions stripped of dignity. The home-based care model of these communities would normally be informal home-based care,<sup>3</sup> with neither support nor recognition.

Poverty is determined, firstly, by measuring the Gross National Product (GNP), i.e. the total value of a nation's annual output of goods and services, thereby classifying countries as low-, middle- or high-income countries. Secondly, it is determined by the Physical Quality of Life Index (PQLI), i.e. the state of people's health and welfare, with the standard factors being: life expectancy, child mortality and adult literacy. Thirdly, it is measured by means of the Basic Needs Approach (BNA), in which the presence or absence of the minimal basic human requirements for life, as well as essential services, indicate the degree of poverty, or the level of standard of living. The basic requirements are: adequate food, safe drinking water, suitable shelter and clothing, as well as basic household equipment; and the services measured are: sanitation, public transport, health and educational facilities (Burkey 1993:4-5). With reference to poor HIV/AIDS-affected people, they are always at the bottom of whatever poverty measuring scale is used.

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<sup>3</sup> See Chapter 6 for discussion of home-based care models.

However, it is important to emphasise that, of all the poverty-measuring approaches, none can completely identify and quantify poverty. But for a working definition of poverty, it would be necessary to indicate that the poor referred to in this book are people who fall below the generally agreed minimum scales, as described above. Furthermore, these people are perceived in their communities (context) as poor.

In wrapping up this section, it is crucial to highlight that pastoral caregivers should have a clear contextual working definition and understanding of poverty. Though there are poverty indicators, one should be warned about the possible dangers of such global indicators. If the income indicators are employed in many rural communities, very few people or none would be above the poverty line in countries such as Zimbabwe, Mozambique or Malawi (just to mention a few). But these people would be clear among themselves about who are the most needy in the area. In such situations it would be unwise to stick rigidly to global indicators, since no one would care and assist others. In fact, in many cases in Africa the concept of relative poverty may be the best way to address the issue of poverty and to mobilise interventions. Communities are aware of the orphans and needy widows who require handouts among them. Therefore pastoral caregivers in poor communities should be sensitive to this fact. The community should define their poor and then jointly intervene. Thus, poverty should be viewed as a local and community issue in mobilising interventions.

### *3.3 Poverty: A Biblical Concept*

Pluralist thinking has permeated many societies, including those in Africa. Though some African people are still tenaciously holding onto their values, the ripples of it are evident. And theology is no exception. Therefore, in this pluralist culture where epistemology is contested, it is crucial for any theological endeavour to appeal to the epistemological foundation of Christianity, i.e. Scripture. Failure to do so means that a theological pursuit could risk becoming indistinguishable from the social sciences. The value of drawing from the Christian normative source is that people would not deviate from God's mission or kingdom focus, though interpretation remains contested. Furthermore, by focusing this pursuit on Scripture, we allow ourselves to be haunted by the reflective question: what does Scripture say? And this continuously shapes our thinking and actions. In this light, therefore, it is paramount to explore the biblical concept of poverty.

#### **3.3.1 Poverty: An Old Testament Concept**

Poverty in the Hebrew Bible denotes (1) lack of economic resources and material goods; and (2) political and legal powerlessness and oppression (Pleins

1992:402). Poverty as lacking material, legal power and oppression is a notion shared by other scholars like Mott (1985:807) and Braaten (2000:1070). However, to grasp the Hebrew conception of poverty, it may be useful to consider the Hebrew words translated as “poverty”. They are *’ebyon*, *dal*, *mahsor*, *miskin*, *ras*, *’ani* and *’anawim* (Brown 1971:820; Pleins 1992:403). In analysing the meaning of these words Pleins (1992:403-414) agrees with other scholars that:

- ~ *’ebyon*- refers to a person who is economically or legally distressed, destitute, beggar, i.e. it generally refers to the beggarly poor;
- ~ *dal*- means poor, weak, inferior or lacking. And in many cases it alludes to the plight of the beleaguered peasant farmer;
- ~ *mahsor*- denotes lack of or need for material goods. It occurs 13 times in the Hebrew Bible and mainly in Proverbs. Its rarity in other parts of the Hebrew Bible suggests that it is a wisdom term;
- ~ *ras*- refers to someone who is politically and economically inferior, frequently referring to someone who is lazy;
- ~ *’ani*- refers to economically poor, oppressed, exploited, suffering, and is the common term in the Hebrew Bible for poverty;
- ~ *’anawim*- is not a common word for poor, but is believed by scholars to be a conjunction of poverty and piety, i.e. poor, pious, humble.

These various Hebrew words translated as “poverty” don’t mean much to a reader apart from their context. Therefore, in his analysis Pleins discourages an etymological approach to the study of words, but encourages a consideration of context and usage. He states that:

*It is important to note the distribution of the vocabulary throughout the Hebrew Bible: no one Biblical writer or text uses all the Hebrew terms for poor/poverty. In fact, the distribution reveals selectivity on the part of the biblical authors: ras, for example, is a wisdom word and not a prophet word. This selectivity should also alert us to the fact that even when the various blocks of the biblical text make use of the same Hebrew term, the writers may not mean the same thing by that term: In proverbs, for example, the dal is a lazy person, whereas for the prophets, the dal is an object of exploitation (1992:403).*

However, while it is undoubtedly difficult to represent the various “poverty concepts” denoted by the above words in their contexts and usages, there is an insightful trend that may be discerned. Braaten (2000:1070-1071) discovered this trend and commented that Old Testament traditions emphasise different aspects. The legal texts regulate the treatment of the poor, seeking to protect the poor, widows, orphans, or strangers (Lev 19:9; 25:25,35). The prophets show a concern for those economically exploited (e.g. Isaiah and Amos). The

wisdom traditions view poverty from different perspectives. Proverbs sees poverty as one's own fault (e.g. Prov. 6:10-11; 10:4; 13:18), while for Job poverty results from political and economic exploitation (e.g. Job 29:12,16; 30:25; 31:16). The Psalms present God as the defender of the poor (e.g. Ps 22:26; 35:10). The narrative literature of the Pentateuch and Deuteronomistic history shows little interest in the poor, but is concerned more with critiquing the kingship.

As highlighted above, the various strands of Old Testament traditions have different focal points. "Nevertheless, the legal, prophetic, wisdom, and liturgical traditions all see poverty as a matter of grave significance to the community" (Pleins 1992:413). The legal and the prophetic traditions present the harsh situations of poverty: hunger and thirst, homelessness, economic exploitation, legal injustices, lack of sufficient farmland. The liturgical tradition (Psalms) presents a God who assists the poor in their distress. In the wisdom tradition, the wise in Proverbs view poverty as either laziness or as representing the judgement of God, but by contrast Job views the poor as victims of economic and legal injustices.

All in all, the Old Testament in its various descriptions denotes the poor as the needy, those without power, and abused by those with greater power. They (the poor) may also not have the capacity to provide the essentials of life for themselves. Their deficiency in life-supporting power is understood to exist in relation to the rest of the community, which also alludes to poverty as contextual and relative, as argued in the previous section (3.2).

### **3.3.2 Poverty: A New Testament Concept**

The New Testament has two Greek words that are translated "poverty/poor". The words are *ptochos* and *penes*.

- ✧ *Ptochos*- is the most common term in the New Testament. It appears 34 times. *Ptochos* literally means beggarly poor (Hanks 1992:45; Brown (1971:821). Brown added that this word signifies utter dependence on society. The person would be so helplessly poor that he/she is at the mercy of other people.
- ✧ *Penes*- is used only once in the New Testament (i.e. 2 Cor 9:9). It refers to the person who cannot live on his property or one who has little and must live frugally (Hanks 1992:415). Though this word is barely used in the New Testament, it was the most common word in ancient Greece.

Much as words translated as "poverty" in the Old Testament should be understood in their context and usage, so the New Testament words should be understood in their context. As mentioned above, *ptochos* occurs 34 times - 24 times of these occurrences are in the gospels (and mostly in Luke). In the

gospels *ptochos* is used in various ways, e.g. in the literal sense (Matt. 10:21; cf. Luk. 18:22) and in a spiritual sense in Mathew (5:3). While undertaking a detailed analysis of the usage of *ptochos* could shed more light on poverty, it is not our main interest. Our interest lies in developing a general understanding of the way that the New Testament presents poverty in order to view this idea in relation to the above discussion.

However, what could be stated precisely in this discussion is that the words for poor in the New Testament cannot be defined exhaustively and statically. But what is apparent is that poverty generally designates a person(s) and group(s) lacking (totally or in some degree) the necessities of life: food drink, clothing, shelter, health, land/employment, freedom, dignity and honour, etc. (cf. Job 24:1-12) (Hanks 1992:415). Furthermore, it is also clear that some kind of option for the poor is represented in most New Testament literature (e.g. Luke).

Finally, in the above discussions (3.2; 3.3.1; 3.3.2) it emerged that poverty is experiential, contextual and relative. The poor's experience of their condition is an important indicator to reveal poverty. Secondly, the people in the community are aware of the poor people around them, though organisations may use global indicators. Thus poverty is relative. These people of the community share a common idea of poor people designated as needy, without power, abused by those in power, and lacking the necessities of life (e.g. Job 24:1-12). The most striking experience for this researcher was to see village people in Zimbabwe dividing 1 kg of sugar to give an old widow whose sons are not employed and living in the village. Poverty is not an abstract concept. It applies strikingly to people in whatever context they are. They see, feel and experience it. Therefore, whether by rules, principles, paradigms or symbols (Hays 1996), the Scriptures instruct the more privileged to care for the less privileged.

### 3.4 *Interplay: Poverty and HIV/AIDS*

Poverty in biblical times was sometimes caused by natural disasters, oppression (e.g. in Prophets) or laziness (e.g. in Proverbs). But in our time there are many other factors,<sup>4</sup> including HIV/AIDS. Therefore, the following related

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<sup>4</sup> Development specialists have identified the following factors as some of the causes of poverty: Causes:

1. Lack of modernisation tendencies;
2. Physical limitations;
3. Bureaucratic stifling of enterprises;
4. Dependency of third world countries;
5. Exploitation by the local elite.

In addition to these factors Pieterse (2001:46-60), focusing on South Africa, added the following factors:

1. Consequences of apartheid;
2. Economic sanctions;
3. Lack of capital for economic development;

questions could be posed. How does poverty cause/increase HIV/AIDS? How does HIV/AIDS in turn cause/increase poverty?

Poverty is likely to top the list of factors that cause HIV/AIDS in Africa. But if one is asked “How?” “Why?” then one may be less certain. It is undoubtedly true that poverty and HIV/AIDS are closely linked, but the challenge lies in delineating the link/relationship. Gillies *et al.* (2000:201) reveal the correlation of these two issues by posing the question: “What evidence is there for AIDS as a disease of poverty?” They respond to this question by analysing the global poverty and HIV/AIDS scenario using 1991 World Bank data. In doing so they focused on Sub-Sahara Africa. They state:

*The Sub-Saharan African region has by far the lowest levels of GNP per capita in 1991, with this being as low as \$120 in Ethiopia and below \$1000 per capita in the majority of the Sub-Saharan countries. The negative correlation between AIDS case rate per 100 000 population and GNP per capita in the region is suggestive of AIDS being associated with very low levels of national wealth (2000:201).*

Gillies *et al.* 1991 data may seem outdated, especially considering the changes that have occurred in Africa in recent years, e.g. the political unrest in Zimbabwe (last 5-7 years) leading to negative economic growth (GDP), and other countries such as Mozambique have improved (Mohr and Fourie 2001:115-137). But the trend that Gillies *et al.* identified is still applicable in that HIV/AIDS case rates are higher in many of the poorer African countries than in wealthier European countries (Gibson 2002:17; Gillies *et al.* 2000:204; Word Bank 2002:2). Furthermore, focusing on the national/country level, this trend is evident also in that poorer people are worse affected by HIV/AIDS (see Matchaba 2001:20-22; Cross 2001:133-147). This apparent link between poverty and HIV/AIDS, therefore, triggers the following fundamental question that probes the nature of the relationship: what is the nature of the interplay between poverty and HIV/AIDS?

The connection between these two issues (i.e. poverty and HIV/AIDS) works in two directions. Poverty increases vulnerability to HIV infection and plunges the family into deeper poverty, and HIV/AIDS exacerbates poverty as the potentially productive person becomes powerless and draws from savings. Consequently, poverty trickles down to the whole family (Online Poverty papers). However, this does not mean that HIV/AIDS is the only factor that causes poverty. There are many other factors, as highlighted above. There are

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4. Effect of unequal income distribution on economic growth rate;
  5. Insufficient competitiveness with the rest of the world;
  6. The financial crisis of 1998;
  7. Economic globalisation;
  8. Reaction to the financial crisis and the role of globalisation in it.



also other factors that cause HIV/AIDS apart from poverty, as highlighted in Chapter 2.

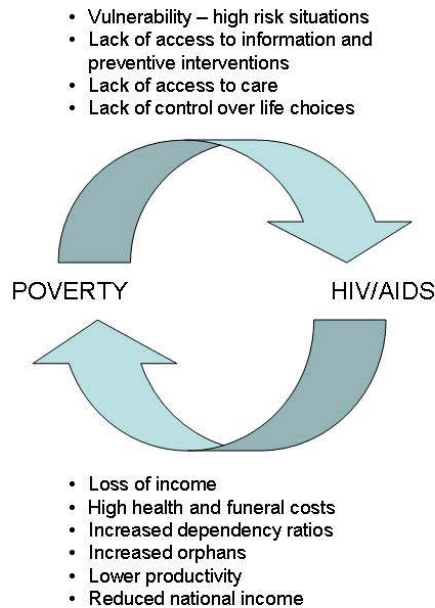
However, though it is a fact that there is a link between HIV/AIDS and poverty, the interactions are myriad, complex and not fully understood. “HIV is not confined to the poorest even though the poor account absolutely for most of those infected” (Cohen 2002:2, *Poverty and HIV/AIDS in Sub-Saharan Africa*). Therefore, regarding the intricate nature of the relationship between poverty and HIV/AIDS, UNFPA wisely comments that:

The relationship between poverty and HIV transmission is not simple. If it were, South Africa might not have Africa’s largest epidemic, for South Africa is rich by African standards. Botswana is also relatively rich, yet this country has the highest levels of infection in the world. While most people with HIV are poor, many others are infected ([www.unfpa.org/swp/2002/english/ch6](http://www.unfpa.org/swp/2002/english/ch6) pp.2).

In saying this, UNFPA is not denying the link between HIV/AIDS and poverty, but is warning people not to adopt a reductive understanding of HIV/AIDS as being caused only by poverty.

The diagram below (Fig. 3.1) summarises the relationship between HIV/AIDS and poverty. It illustrates how a family that provides HIV/AIDS home-based care can be affected by HIV/AIDS and how poverty in turn may increase vulnerability.

**Fig. 3.1:** Poverty and HIV/AIDS interplay (Online poverty papers)



### 3.4.1 Poverty to HIV/AIDS

#### 3.4.1.1 Vulnerability - high-risk situations

Poor people are vulnerable to HIV/AIDS and are often in high-risk situations, e.g. homelessness<sup>5</sup> and migration. These situations leave them with little choice but to participate in risk behaviours.

The first group of the homeless who live on the streets have very little or no education, hence they have very little or no prospects for a better life. Life to them is meaningless. The multiple sexual partners and the drug-using culture of these people exposes them to HIV/AIDS. In Zimbabwe an attempt to stop or discourage them from engaging in risky activities is often met with the response *kusiri kufa ndekupi?* (lit. what is not death?). By saying this they mean

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<sup>5</sup> “Homeless” technically refers to people without a roof over their heads and/or living on street corners. But in Africa the “homeless” concept could be extrapolated to refer to people in informal settlements (shacks in South Africa and *zvitangwena* or boards in Zimbabwe) because of the high-risk activities that they engage in and the temporary nature of the houses. Though many of these people may have decent rural homes, for the time that they are in the cities they live in deplorable conditions that expose them to high-risk activities.

that life and death to them are not different. They argue that they may die today or tomorrow of hunger, so they can do whatever they feel like doing. In fact, they argue that HIV/AIDS is better than hunger because it prolongs your life rather than dying of starvation in few days. HIV/AIDS prevention is not a priority. A plate of food is more valuable than worrying of HIV/AIDS. They sell sex to anyone who offers them money. Fernandez (Online) summed it simply as follows: "Many of these people participate in informal activities, such as prostitution and intravenous drug use, which has implications for HIV".

The second group of the homeless living in informal settlements also engage in high-risk activities such as selling sex as a means of survival. The NMH report (2002:21) revealed that in South Africa the highest number of HIV/AIDS cases (28.4%) are found in urban informal settlements, followed by 15.8% in urban formal settlements, and the rural areas have the lowest figure of 12.4% in the 15-49 year age range. Apart from the economic reasons, some engage in sex for entertainment.

Another strand of the implications of poverty for increased risk behaviour in HIV/AIDS transmission is rural urban migration. Poor people in rural areas migrate to cities expecting to find formal employment, but they usually are employed in low-skilled jobs, as farm labourers, and some fail to find employment and end up in high-risk behaviour such as prostitution and drug peddling. A study that was done on women and HIV/AIDS revealed that the majority of women in the sex trade are the unemployed from poor minority groups (Fernandez Online).<sup>6</sup>

Another clear and insightful dimension in understanding the risky activities was noted and emphasised by Jochelson *et al.* (1991). They observed that the system of migrant labour in the South African mining industry facilitates the spread of HIV/AIDS. Separation from their wives and families for long periods of time, poor conditions in mining hostels which are surrounded by security fences and where there is no privacy, coupled with low wages, conspire to make life quite miserable for the migrant workers. In discussion with these men, they described how contact with prostitutes offered not only sexual satisfaction, but allowed them to enjoy female company and receive some measure of comfort and relief from the harsh realities of the mining existence. Therefore the need for satisfaction push (males) and the ready cash pull (prostitutes) stimulates the sex market – hence the spread of HIV/AIDS. Though there has lately been an improvement in the mineworkers' conditions as a result of government pressure, this sexual culture is still thriving.

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<sup>6</sup> In a discussion (July 2003) with Professor Jan du Toit, Director of the African Centre for HIV Management (Stellenbosch University), he said that he had many conversations with male prostitutes in Cape Town and discovered that most of the immigrants involved had families back home and they were driven to do this by poverty.

*3.4.1.2 Lack of access to information, preventive interventions and access to care<sup>7</sup>*

The HIV/AIDS awareness programmes conducted through the radio and television sometimes do not reach to the poor. This crucial information that they need to know is hampered by inappropriate dissemination methods. The NMH (2002:21) report revealed that the media are a powerful influence that make people take HIV/AIDS seriously, i.e. television, radio, billboards and leaflets. The programmes are often in English, yet the level of education of the poor majority is very low. Besides, many poor people cannot afford televisions and radios. Hence the report emphasises that “lower levels of access to mass media channels in rural communities and poor households should be noted” (2002:20). Thus Whiteside (2001:1, 5) too notes that “poverty and the lack of knowledge are also linked”.

Also at national level government resources are thinly spread, since many of the African governments cannot meet the costs effectively. The few government resources often target the privileged of the country, neglecting the country's poor. Scarcity of resources has further implications in poor countries in that very little research has been done to identify the factors that lead to the spread of HIV/AIDS (Fernandez). Hence the poor are often overlooked.

Established epidemics of other sexually transmitted diseases (STDs) increase the likelihood of HIV/AIDS (Greyling 2001:4). Untreated STDs make sexual organs' surface environments favourable for transmission. Poor communities have fewer health facilities than rich communities, which makes it difficult for STDs to be treated. Furthermore, they lack funds to buy medication. Recently (March 2004) in Zimbabwe, as a result of the economic crisis, government hospitals that used to cater for the poor are not getting sufficient medication to treat infections, hence they are failing to cope. Furthermore, the hospitals are understaffed. It is only the expensive private hospitals that provide effective care and medication, which is far beyond the reach of the poor. These private hospitals charge up to R1500 (or \$200) upfront before patients are attended to. In such situations the poor who are infected do not even bother to seek medication, hence making HIV/AIDS transmission highly likely. However, the distribution of condoms as a preventive measure is being carried out through NGOs in many different countries.

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<sup>7</sup> The AIDS Bulletin 92004:12) cites the leading credible HIV/AIDS report sources - USAID, UNAIDS, WHO and UNICEF on low- and middle-income countries (end 2003). The report indicates that most people in these countries do not have access to key prevention services. Only 0,2 of adults aged between 15-49 are utilising counselling and testing services, and only 8% of pregnant women have access to services to prevent mother-to-child transmission. Only 3% of HIV+ pregnant women receive AZT or Nevirapine to prevent mother-to-child transmission. Furthermore, this highlights the fact that services are generally located in cities and other urban areas, while the poor in rural areas are neglected.

### 3.4.1.3 Lack of control over life's choices

Throughout the world women make up the majority of the lower social strata. Pieterse (2001:36), citing May and Govendor's research, noted that

*Among female heads of households the poverty rate is 60%.<sup>8</sup> This is much higher than the rate for male headed households. Households headed by women are concentrated in rural areas, where the poverty rate is particularly high. These households also have fewer adults who are old enough to work, and the unemployment rate for women is higher than that of men (20001:3).*

Poverty among women has negative HIV/AIDS implications. A third of women canvassed at three antenatal clinics in a study in Soweto admitted to having had transactional sex in return for food, clothing, transportation, schools fees, cash or gifts for their children, and were HIV positive (AIDS Bulletin, Sept-Oct, 2002; see also Hunter 2001:26-28). Greyling (2001:3) added that even among married women there is a high level of economic maltreatment. The South African Department of Health's Demographic and Health survey of 1998 revealed that the partners of one in five married women regularly withheld money for essential living expenses such as food, rent or bills, while spending money on other things. Many women face the risk of abandonment and abuse if they disclose their HIV-positive status. These exploitative tendencies are high among poor uneducated women, who can't stand up for their rights. In fact, though they may attempt to voice their concerns, the society in which they live may suppress them. In fact, the risk of becoming infected with HIV/AIDS is two to four times higher for women than it is for men (Van Dyk 2002:209ff; Ziyambi 2002:37).

Apart from the exploitation of women, children born under the culture of poverty have higher chances of being poor and so the poverty-HIV/AIDS cycle is repeated. Cohen (2002:4) is right that the characteristics of poverty are known to be some of the causal factors of the culture of poverty, i.e. children of the poor often become the poor of subsequent generations. As poor people do not have enough money to pay for their education, their low literacy level makes them less marketable and less productive.

The vicious cycle of poverty-HIV/AIDS is also evident when parents die and the children have no one to take care of them. They end up engaging in high-risk behaviour. Therefore, home-based care should also focus seriously on orphans. In summary, poor people are affected by a host of factors: under-nourishment; lack of clean water, sanitation and hygienic living conditions; generally low levels of health; a compromised immune system; a high incidence of other

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<sup>8</sup> Chambers (1980:17) also emphasises that many of the poorest households have female heads.

infections, including genital infections; exposure to diseases such as tuberculosis and malaria; inadequate public health services; illiteracy and ignorance, and pressures that encourage high-risk behaviour (UNFPA 2002:2). Furthermore, the situation worsens when the children are orphaned.

Lack of control over life's choices, especially regarding sexuality, in Africa is sometimes misinterpreted and in other instances not explained. For instance, the NMH (2002:9) report revealed the following prevalence of HIV/AIDS.

Age group	15-19	20-24	30-34
Males	4%	8%	24%
Females	7%	17%	24%

The report does not explain this trend. Nonetheless, one possible explanation to account for the differences could be poverty. African men prefer female partners younger than them. In that case older men who have resources scout for younger women, say in the 15-19 or 20-24 age group. And for financial benefits these women are attracted to these men, leaving men of their own age who are still working towards establishing themselves professionally. But as they get to the 30s the figures level up. Another factor that may cause this scenario is the need to save money to pay *lobola* (bride price). The man has to work for some years, so he delays marriage and by the time he has enough money he prefers a younger woman. This has two implications: the man would be involved in sexual relations while he delays marriage and, secondly, the helpless young women who are the prey for men are normally not in a position to bargain for sex because of cultural values, age gap and material privileges. It is easier to control a sexual relationship with someone of the same age than with an older person, especially a man in Africa. Young women, therefore, become more vulnerable than young men. This could be a possible explanation to the above case. Women sometimes can't control their life choices.

The issue is not so much abuse of power as a result of the hierarchical structure, as some writers claim. Gift sex is not seen as prostitution and is common in many societies (Greyling 2001:6). And often the men who can afford gift sex are the older ones who are relatively stable financially and can spare money for gift sex with the young women. It is untrue simply to say African women have no control over sexual matters. This may be evidenced by the high resistance expected of women over sexual matters in some African communities. How can they resist if the social structure does not support them? In fact, among the Shona group in Zimbabwe, to which the researcher belongs, women are referred to as the *key holders to sex not men!* The poverty factor, however, comes to play in the sense that older men are the ones with money to attract the poor young women, thereby reflecting the above scenario.

#### *3.4.1.4 Summary and critical note: Poverty to HIV/AIDS*

In summing up how poverty increases the risk and worsens the impact of HIV/AIDS in African families, Greyling (2001:5-6) outlined in a simplified manner points that are complementary to the ones discussed above. They are as follows:

- ☞ Poverty reduces children's chances of attending school; this in turn lowers their chances of gaining employment and increases the risk of HIV/AIDS infection. Children often have to drop out of school to care for the sick family members, for their younger siblings, or to look for work. Children lose the chance to "be children" because of these additional responsibilities.
- ☞ Poverty increases the likelihood that young women (and men) turn to commercial sex work, selling their bodies to survive, to gain an income to support younger siblings, to secure their next meal, to gain shelter, money for school fees, etc.
- ☞ Young people living in poverty often have low levels of self-esteem and desire the material things their friends have, which may put them at risk of HIV/AIDS infection through becoming involved with "sugar daddies", taxi drivers, etc. - people who can give them material things they wish for. "Gift sex" is not seen as prostitution and is extremely common in many societies.
- ☞ As parents fall ill with AIDS, they can devote no time to parenting their children, leading to risk-taking behaviour among young people because of the lack of attention and guidance. Risk behaviour often leads to unsafe sexual activity, and in turn, to HIV infection.
- ☞ Some children are intentionally neglected and abused or forced to take on household tasks when they are taken in by relatives or other families because of illness or the death of their parents - they are also at risk of HIV infection as their own self-esteem plummets as a result of this abuse.
- ☞ According to home-based care providers, many AIDS patients die of malnutrition and not primarily of AIDS-related illnesses - people simply do not have sufficient food, leading to premature death even in the face AIDS.

These explanations are sketchy, but they also underline some of the issues discussed above. They should be read in conjunction with the above discussion.

It is also important to note from the discussion that, though there is a correlation between poverty and HIV/AIDS, as mentioned earlier, the interactions are complex and not fully understood. A simplistic approach should be avoided. Pieterse (2001:36) and many other scholars agree that poverty is highest in rural areas. Hence from the poverty-HIV/AIDS relationship discussed, the possible trend could be expected to be: high poverty levels in

the rural areas, therefore higher HIV/AIDS cases, and fewer HIV/AIDS cases in the urban areas (because there is less poverty). However, the contrary is true. The Zimbabwe National HIV/AIDS Estimates (2003:11) shows that the urban areas have 28.1% cases (i.e. more) and the rural areas have 20.9% (i.e. less). The NMH (2002:2) in South Africa shows a similar trend to the one in Zimbabwe, i.e. 15.8% in urban (higher) and 12.4 % in rural in rural (lower).

Furthermore, as mentioned earlier, Botswana is richer than many African countries, but it has the highest number of HIV/AIDS cases in the world. In fact, the Halperin and Allen (2000) research report in *AIDS Analysis Africa* revealed that rapid economic growth in Botswana resulted in a breakdown of traditional ways of life, which in turn fans the epidemic further. South Africa is also fairly rich by African standards, yet has the fastest growing HIV/AIDS pandemic in the world (Loening-Voysey 2002). Therefore the question that springs to mind is: why the contradiction?

The poverty and HIV/AIDS relationship cannot be fully understood by focusing on statistics. For instance, the March 2003 country profile study on poverty for Zimbabwe shows that poverty is 53.4% in urban and 86.4% in the rural ([http: www.jica.go.jp/English/global.pov/profiles/pdf/zim eng.pdf](http://www.jica.go.jp/English/global.pov/profiles/pdf/zim_eng.pdf) 2003:1). The profile report further explains that

*88% of the poor and 92% of the very poor are concentrated in the rural area. Most of the people in rural area are agricultural farmers, and their income largely depends on the quality of land and the agricultural productivity (2003:4).*

These international organisations are correct according to the global indicators that rural people are poorest. But the approach cannot explain the poverty and HIV/AIDS scenario. The probable explanation could be that, though rural people may not have a wage income or enough money to pay their children's fees up to high school and university, they often have enough food for the family through subsistence farming. For urban people, when one is unemployed and does not have money to meet one's daily needs, the situation is desperate. Furthermore, the setting of rural communities/villages allows for one to get handouts from neighbours, which is not the case in cities. The urban poor then are pushed by their desperate poverty circumstances to engage in risk behaviours leading to HIV/AIDS infection. In fact, many African people's wages are barely enough to meet all their needs, hence some engage in risk activities or sell goods to supplement their wages. A typical example is that of a Zimbabwean female teacher who was reported in the Zimbabwe daily newspaper *The Herald* few years ago to be engaging in prostitution. In defending her actions, she argued that the salary was not enough to meet all her needs. Though this woman's case may be an extreme one, it illustrates how desperate people could become in the cities. Many examples could be cited



from college and university students in the urban areas who engage in risk activities as an alternative means to supplement their allowances. These conditions of poverty lead to higher HIV/AIDS infection rates.

Another important factor that may account for the low HIV/AIDS cases in rural areas, though they may be poorer, is the strong socio-cultural fibre. Many rural communities still uphold cultural moral values. It is an embarrassment to the family and community for a man to have multiple girl friends. If a man loves a woman, he is expected to marry and settle. And it is the same with women. It is socially unacceptable for women to change partners, even though it is one at a time. Moving from one partner to another shows loose moral values. The community ensures that the values are upheld.

Halperin (2001:12-15) suggests that other factors, including the breakdown of traditional ways of life in developing countries, play an important role in fanning HIV/AIDS besides poverty. Mcetywa (2002), in his article "HIV/AIDS a Traditional Religious Perspective" focusing on the AmaMpondo people in South Africa (Eastern Cape), gives an example of rural people's robust and close-knit conservative moral values that prevent HIV/AIDS. He said,

*According to traditional Mpondo communities, there is free talk about sex, approved sexual group gatherings, which are supervised by the elderly people of the community. The general safety of the whole community is the responsibility of every member of the society. It is recognised that the actions of one person can have negative impact on the whole community. The society does not favour nor dictate to its female members. The bottom line is to ensure that the whole community is healthy in all respects (2000:60).*

This strong moral fibre and cultural conservatism reminiscent of many rural African communities reduces HIV/AIDS infections in comparison to the urban communities. However, this does not imply that all rural practices reduce HIV/AIDS rates of infection, since some actually fan it, as discussed in Chapter 2. Therefore, though the rural communities may be poorer in terms of global indicators, the people are likely to survive even with little or no cash. Hence high standards of morality coupled with livable environments reduce the prevalence of HIV/AIDS, which is not the case in cities.

To close the discussion, the initial question could be posed again: how then does poverty increase/cause HIV/AIDS? The answer is twofold. Firstly, from the discussion it emerged that poverty increases poor people's vulnerability to HIV/AIDS (i.e. poverty is a push factor). It leaves poor people with little or no alternative but to indulge in risky HIV/AIDS activities. Secondly, it accelerates immunity depletion due to poor nutrition (i.e. the poor infected person dies

sooner). Having seen how poverty causes/increases HIV/AIDS, how then does HIV/AIDS increase poverty in turn?

### **3.4.2 HIV/AIDS to Poverty**

Poverty is a factor that facilitates the spread of HIV/AIDS, as has been discussed in the previous section. Poverty pushes one to engage in risk behaviours leading to the contraction of HIV/AIDS. And HIV/AIDS in turn also causes poverty by directly draining the resources of the affected people.

Laubscher and Malunga, who are economists of Sanlam, in their paper “The impact of the HIV/AIDS pandemic on the South African Economy and Financial Markets” clearly outlined ways in which HIV/AIDS renders a country poor. The macroeconomic impact includes the fiscal impact, economic growth and unemployment, household consumption expenditure, private sector capital formation, inflation and interest rates, and modelling results; microeconomic, i.e. recruitment and training costs, absenteeism and productivity, employee benefits, market share, and profitability; sectoral considerations; and implications for investment, i.e. bonds, property, equities, and asset allocation (n.d.:9).<sup>9</sup> In the same way, Okonmah (2003:1-8) in his paper “Social and Economic Impact of HIV/AIDS in Africa”, also emphasises the economic impact, but he goes further to consider the social dimension. He lists the impact on society, the economy, economic growth, human development, households, productivity in commercial and subsistence agriculture, mining and crude oil extraction, and government.

However, while our interest lies in the impact of HIV/AIDS on the family/home, it is also important to note that the home/family exists in a web of other macro-factors such as outlined above. Okonmah (2003:8), therefore, in agreement with Danziger (2000:41-55), International Water Sanitation Centre on Poverty alleviation, and Colvin and Sharp (2001), succinctly sums the poverty-related facets of HIV/AIDS:

*HIV/AIDS has impoverished individuals, families, communities and governments. Individuals and /or families are constantly faced with an exorbitant medical cost, depleting all their savings and even forcing them to dispose of their assets such as land, houses, etc. with government funds and household savings being diverted to purchase health and health related goods and services, less capital is available for investment and ultimately resulting in a significantly stunted growth in the economy (GDP, GNP and employment). An erosion in the human resource base, due to HIV/AIDS deaths, has also resulted in a reduced*

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<sup>9</sup> For a fuller discussion on how each of these issues is affected by HIV/AIDS, see their paper.

*growth in productivity, capital generation, and labour industries. Agriculture, mining and crude oil extraction account for a significant proportion on the GDP in most of the African countries where they also serve as the major sources of employment for the people (2003:8).*

The above summary by Okonmah is useful as a starting point to focus specifically on how the pandemic impacts on individual families.

#### *3.4.2.1 Loss of income*

Some employers require a medical report from employees. If a person is HIV positive then they may be reluctant to employ him/her. Greyling (2001:5) added that many employers, seeing the impact of HIV/AIDS on their workplaces, are not employing staff with full benefits, but rather take them on as temporary staff with no benefits such as medical aid, etc. This then means that pensions, etc. will not be available to meet family needs when they are most needed and payouts will no doubt be consumed as they are received, not invested or kept until all other resources have been exhausted. Loss of income can also be extended to include agriculture. Families that rely on family labour (subsistence), especially healthy parents, will be severely affected when parents are bedridden.

#### *3.4.2.2 High health and funeral expenses*

An HIV-infected woman appeared on e-tv news (19:00h) on 15 June 2004 explaining that she was spending R1500 a month on antiretroviral drugs before the government intervened. This is an example of how HIV/AIDS can drain a family's savings. In other poorer African countries, proper medical care is only offered in private hospitals, because government hospitals have no drugs and are understaffed. This means HIV/AIDS-infected people have to incur huge medical expenses in these hospitals. This researcher's brother had to sell his two cars in order to meet medical costs before he eventually died in 2002. It is a heart-rending experience to see a person becoming poorer each day as HIV/AIDS drains family resources.

Greyling, Cohen, Okonmah, Danziger and many other writers on HIV/AIDS agree on how health and funeral costs impoverish a family; Greyling (2001:5) sums this up in the following words:

- ~ As a person progresses from HIV infection to AIDS, they suffer many bouts of illness for which they seek treatment. In the process they spend money on medical care, traditional healers, etc. as well as on nutrition and supplements to help them remain healthy for a long period of time.
- ~ Those members of the household who are in the weakest positions suffer the most - in affected households, health expenditure for infected people

increases, while spending on food and other essentials decreases, impacting on women and children.

- ~ Burial costs are increasing because of the shortage of grave space in urban cemeteries.
- ~ Funerals are a very expensive but important element of a cultural tradition and a great deal of money is spent on food and drink for the duration of the funeral. Funerals extend over a number of days and are attended by family, extended family and the community at large. Therefore funerals continue to be costly and consume valuable resources, which could have been used by the surviving family members. The impact of a death is most serious on poorer households.

#### *3.4.2.3 Increased dependency ratios and orphans*

One of the advantages of Africa's extended family structure in the wake of the HIV/AIDS pandemic is the close-knit relationship network. It allows for easy orphan adoption. But in many communities this is a fading practice. Nonetheless, even in places where it is still the case, there has been a shift from chiefly being agrarian to wage living. In many cases the few young and active parents are the ones employed in manual labour. But with HIV/AIDS infecting young people, often grandparents are the ones left with the burden of caring for grandchildren. This scenario is clearly depicted in the story below narrated by a grandparent (Lucy) in Cohen's paper (see also Ewing 2000:10-13).

By the time my sons became ill with AIDS, one of my daughters-in-law had already died of tuberculosis, and the other had become mentally sick. So I was the closest person to my sons. I had to resume the role of a mother caring for her sick children. I was the only one who could ensure that their physical and emotional needs are met. It was very touching having to nurse my sons again and watching them bed-ridden and deteriorating day by day. My heart shrank whenever I thought of caring for my grandchildren after the death of their fathers. Their sickness had started encroaching on the savings I had made for my own welfare in old age. It was very painful watching them die. When I was a young girl of 17 getting married, I never dreamed that someday I would see three of my sons die.

My sons left behind 6 orphans, and now I am once again a mother to children ranging in age from 8 to 15. Two of my grandchildren were also HIV infected. One has already died, and one is still living at age 8, though she has started falling sick. I am taking care of them alone because in our culture, it is the family of the father who must care for orphans. This is a great challenge having to look after young children again after counting myself among those who had graduated from the responsibility of being a mother.

Before my sons became ill, I had hoped that my role as a grandmother would be to care for my grandchildren occasionally during school holidays, but now I am alone in caring for them. In the old days, children were not exposed to so many outside influences, but now Ugandan society has changed so much. I find that some of the tactics I used to instil discipline in my own children no longer yield the desired response from my grandchildren. I find the children less respectful and undisciplined in spite of my effort. I feel so sad that I have gone back to the beginning and I have to struggle to get resources to ensure that their basic needs are met, such as school fees, medical care, clothing and other needs. Lucy

As Lucy narrates in the above story, when parents die and there is no one to look after the orphans, they become vulnerable. They easily become the poor of the next generation, i.e. generating a culture of poverty. Kevina's story below, also from Cohen, shows this situation clearly.

My names are Kevina Lubowa. I am 14 years old. I have 4 brothers and 3 sisters younger than me. I come from Uganda. I am studying in Primary Six. I have come here to say something about AIDS and its problems.

AIDS means acquired immune-deficiency syndrome. It's a terrible disease. It killed both my mother and father in 1992. It killed all brothers and sisters of my father. It has killed many men and women in Uganda.

Some houses have been closed. But our house was not closed because my father and mother left me with four brothers and two sisters. I look after them. I also look after my grandfather who lives near us, because his wife died and nobody was there to look after him. He is 84 years old. He lost his wife in 1992. The grandfather does not see. He has eye problems. It is me who looks after the family.

From school, I go to bring water from the well. I take a jerrican on my head. I tell my brothers and sisters to go in the bush and collect firewood. Sometimes, when we don't have fire, we go and get it from our neighbours. We cook potatoes, matooke, pumpkins and casava. But my brothers do not want cassava; they want only matooke. Our banana plantation is now a forest. We dig in our plantation on holidays and on Saturday. Our food is not enough. Some days we don't get food. We eat cassava with boiled water as sauce. We don't have money to buy sugar or tea leaves.

In the evening I make up beds for my young sisters and brothers. Every week we cut grass to use as our mattresses. We all sleep together and cover ourselves with blankets. Sometimes we sleep in the corner

of the house because our house is leaking. Our blankets get wet and we put them near the fire or in the sun to dry.

There is the problem of disease. We get sick and go to the dispensary. At the dispensary they want money but we don't have the money. They give only tablets. We walk from home to the dispensary. You cannot stop a car because they also want money. Old women help us and give us leaves and mululuza to chew. This helps to get rid of fever.

Because I am a girl, people think I am weak. So they come home and steal our cassava and firewood. Because I am a girl, even when I see them I can do nothing. Some people in the village are not friends. They shout at us, they don't give us advice; we don't have any one to call father or mother; we feel sad when we see other children laughing with their father and mother. In short, this is how I find life.

But other orphans have the same life. They don't have blankets; they don't eat meat; they don't have sugar; they sleep in huts.. Some go to eat at the neighbours or they get one meal a day. At school, life is good. The teacher calls us orphans, but I don't want that name. Even other children don't want that name. We think we are animals.

My friends, I am concluding by saying that the life of an orphan in Uganda is bad. Some people want us to work as their house girls and house boys. Now we want good food, blankets, education and many other things. We also want to live in good houses. So orphans need help. We need to grow and to be proud and happy people.

Let me stop here. Thank you very much. Merci beaucoup.

Kevina

#### *3.4.2.4 Summary: HIV/AIDS to Poverty*

Lucy's and Kevina's stories are two examples of the many stories that people affected by HIV/AIDS can narrate. Many African people have experienced the HIV/AIDS death of either a close relative or friend and they can easily relate to them. The key points of this discussion could be summarised in various ways, but importantly what emerged either explicitly or implicitly from the discussion could be linked to the following three assertions. HIV/AIDS causes poverty through:

- ≈ Draining households' income (also through unemployment) by increasing health and funeral expenditures, which may lead to liquidating of assets such as land, livestock or goods like a car to cover expenses. Furthermore there is loss of subsistence labour;
- ≈ Consumption on family spending (e.g. food and general upkeep), which declines significantly in HIV/AIDS-affected households, while medical care costs rise;

- ✎ Orphans being less likely to attend school (or at least get quality education), hence they are unlikely to be employed, making them further vulnerable to seduction and infection, and becoming the poor of the succeeding generation (culture of poverty).

The issues discussed above are evident in many communities where churches are located in Africa. The church, therefore, should be sensitive to people who are in such situations.<sup>10</sup>

### 3.5 Summary and Conclusion

The premise of this chapter is that poverty and HIV/AIDS are inter-related phenomena. Hence the following basic question was posed: what is the nature of the relationship between poverty and HIV/AIDS in Africa? And from the main question, further questions were asked to illuminate the discussion. What is poverty? What is the biblical meaning of poverty? What is the nature of the interplay between poverty and HIV/AIDS?

The following observations and conclusions emerged from the discussion:

- ✎ Poverty is a term that is difficult to define clearly. The World Bank and other international organisations determine/define it in terms of Gross National Product (GDP), i.e. the total value of a nation's annual output of goods and services; Physical Quality of Life Index (PQLI), i.e. the state of people's health and welfare standard factors; and Basic Needs Approach (BNA), i.e. presence or absence of minimal basic human requirements for life. These approaches help to quantify poverty and determine the poverty line, which is vital to determine countries that require poverty alleviation funding.

But importantly, poverty is experiential, contextual and relative. Communities are aware of the poor among them, according to their own standards. And it is this approach to understanding poverty that is crucial for home-based care. The church within its community in consultation with the church members should identify the community's poor people and assist where possible.

- ✎ Poverty in the Bible is denoted by various words. In the Old Testament it is denoted by *'ebyon*, *dal*, *mahsor*, *ras*, *'ani* and *'anwim*. However, though one could attempt to understand the meaning of poor from the usage of these various words, contextual usage is the most enlightening. Depending on the tradition and background, authors may use the same word differently. For instance, *dal* means a lazy person in Proverbs, but in the prophets is an

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<sup>10</sup> Families affected by HIV/AIDS and poverty.

object of exploitation. In the New Testament *ptochos* and *penes* denote poverty. In all the various Old Testament and New Testament renderings of the term “poverty”, what is apparent is that it is also experiential, contextual and relative. The people of the Bible shared a common communal idea of poverty. But the general designation of the poor person was one who is needy, without power, abused by those in power and lacking the necessities of life (cf. Job 24:1-12).

- The nature of the interplay between poverty and HIV/AIDS works in two directions. Poverty increases poor people’s vulnerability, e.g. through risk behaviour (i.e. poverty is a push factor), and accelerates immunity depletion due to poor nutrition (i.e. the poor probably die sooner than wealthier people). The chief risk behaviour is, among others, selling sex. Other factors also – such as lack of access to information and preventive interventions, and loss of access to care – account for poor people’s vulnerability. HIV/AIDS in turn exacerbates poverty as the potentially productive person in the home becomes powerless and draws from savings. Household income is eroded through high medical and funeral costs. Employers may also be reluctant to employ people living with HIV/AIDS, thereby such people become more impoverished. Orphans may not attend school, thereby becoming the poor of the succeeding generation (vicious cycle of poverty).

However, importantly, though there is an apparently clear relationship between poverty and HIV/AIDS, a simplistic approach should be avoided. The interactions are myriad, complex and not fully understood. Therefore, one is encouraged always to do a contextual analysis to determine the specific factors responsible for fanning HIV/AIDS in any particular situation.

The discussion on the interplay between poverty and HIV/AIDS reveals that the poor are in need and they should be cared for. Therefore, the following questions should be posed: what role/function can the church play with respect to the poor and HIV/AIDS-affected people? What is the theological basis for the church to be involved with the poor and HIV/AIDS-infected people? The response to these questions is the focus of Chapter 4.



# IV.

## *The HIV/AIDS Pandemic*

### *A Challenge to a Practical Theological Ecclesiology*

#### *4.1 Introduction*

Chapter 2 provided an overview of current HIV/AIDS information and the issues related to the pandemic in Africa, while Chapter 3 examined the interplay between HIV/AIDS and poverty. These chapters thus highlight the African HIV/AIDS scenario and its concomitant entanglement with poverty. But what is the responsibility of the church in such a situation? Can there be a practical ecclesiological approach that addresses the twin challenge of HIV/AIDS and poverty in Africa?

This chapter argues for a practical ecclesiological approach driven by the family metaphor as a responsive paradigm. It hinges on the assumption that for the church (*koinonia*) to be a practical and effective conduit of God's love and compassion to the poor and HIV/AIDS-affected people, it should translate/concretise the gospel to real-life situations. The concretisation could be possible through the mutual care of the *koinonia*. In order to do this, an ecclesiological model should shift from a stance of apathy towards one of empathy and contextual engagement.

In concretising the gospel to real-life issues, the church should embody the image or metaphor of family. The implication for our being the church within the HIV/AIDS pandemic is that ecclesiology should understand the church as a network of dynamic interactions. Hence the importance of a systems approach.

The church becomes a horizon where word (theory or reflection) and action or praxis merge, i.e. the mutual care and service (*diakonia*) within the fellowship of the body (church).

The chapter therefore attempts to unveil the theological basis for a church family system approach (i.e. *koinonia* practice). Thus the following questions should be posed: what is the theological basis for an understanding of church within the family metaphor and how should such a metaphor be implemented within a poor community dealing with the HIV/AIDS pandemic? How does the church-family metaphor in Scripture capture and stress Christian responsibility towards one another and to society, which can be applied to encourage care for the poor and HIV/AIDS-affected people? How is the family system approach implied in Scripture connected to the notion of the extended family in Africa? What are the implications for an ecclesiology that is focused on the desperate situation of poor communities?

## 4.2 *The Understanding of Church within a Practical Theological Ecclesiology*

### 4.2.1 **Definition and description of Church (*ekklesia*)**

The word church comes from the Greek adjective, *to kuriakon*, used first of the house of the Lord, and then his people (Clouse 2001:246; Hill 1988:185). But it is always used in the Bible to translate the Greek word *ekklesia*. However, it is important to underline that *ekklesia* does not refer to a building but to an assembly of people (Hill 1988:186).

*Ekklesia* (noun) is a word derived from the verb *ekkaleo* meaning to summon or to call out. The closest English equivalent of the word is convocation – a calling together, an assembly. It was the official term for the Athenian democracy. And it is in this secular sense that it is used in Acts 19:32, 39, 41 (Hill 1988:186). However, the New Testament use of *ekklesia* is controlled by its employment in the Septuagint (LXX) to translate the Hebrew *qahal*, which has the same meaning of a convened assembly (Grudem 1994:853). In the strongest sense the *qahal* is the assembly of Israel convened by God (Deut. 23:2-9; 1 Chronicles 28:8; Numbers 16:3, 20:4, etc.). Thus in the New Testament *ekklesia* is used of a public assemblage summoned by a herald and in the Old Testament (LXX) refers to the assembly of the Israelites, especially gathered before the Lord (Clouse 2001:246; Gehman 1990:175; Best 1985:168; Hill 1988:186; Grudem 1994:853-854; Clowney 1988:140).

Therefore, both in the New Testament and Old Testament (LXX) *ekklesia* denotes an assembly of people called together, which could be taken as the church. Thus Israel can be referred to as the Old Testament church, while in

the New Testament the church includes Jews and Gentiles (Eph. 2:19). However, it is very important to note that the New Testament designation of church and Israel in the Old Testament cannot always be used synonymously. The common designation of Israel was God's people, which could directly parallel God's people (i.e. the church) in the New Testament. Though *qahal* is translated as *ekklesia*, it precisely refers to an assembly, which is not always the correct designation of church, since the church is about all God's people everywhere and not just an assembly at a certain place.

But how does one become part of the church or people of God? It is through embracing Christ through faith that one becomes part of the church or God's people. Thus "the church is the community of all true believers for all time" (Grudem 1994:853). It is visible and invisible.<sup>1</sup> Furthermore, it is local and universal. It may apply to a group of believers at any level - from small group in a house (Rom 16:5; 1 Cor 16:19) to all the true believers in the universal church (Eph 5:25; 1 Cor 12:28), including a region also (Acts 9:31).

My concern, however, is with the function of the church - thus how the community of believers functions in our situation of HIV/AIDS and poverty. To gain an insight into the role and function of the church, I consider it within the practical theological realm.

#### 4.2.2 Praxis and practice: a practical theological perspective

Smit (2003), in the article "On learning to see? A Reformed Perspective on the Church and the Poor", argues that the church should not be "docetic". The church should "see and respond to suffering people in personal and creative ways" (2003:66). Smit's concern and argument - as shared by Louw (1998:2) - is that Christianity should not be a sterile objectivism, a transcended dimension that excludes the realities of being human. It should interpret and understand the Christian truth in terms of human experience in the world. Thus the challenge of the Church to interpret God and salvation in terms of contextual life issues relates to practical theology.

Ballard and Pritchard (1996:4) state that practical theology in our time could be said to be at the cutting edge of Christianity's encounter with important aspects of modern culture. They added that it covers the wide spectrum from those practising ministry to the ordinary congregant members concerning ecclesial issues of living out the life of faith.

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<sup>1</sup> In its spiritual reality as the fellowship of all genuine believers, the church is invisible. This is because we cannot see the spiritual condition of people's hearts. We cannot see outwardly those who attend church, but God knows. "The Lord knows those who are his" (2 Timothy 2:19). The invisible church therefore refers to the church as God sees it. But also the true church of Christ is visible, i.e. those who profess faith in Christ and give evidence of that faith in their lives. The visible church therefore is the church as Christians on earth see it (Grudem 1994:855-856).

Thus Fowler (1983:149) defines practical theology as a

*Theological reflection and construction arising out of and giving to a community of faith in the praxis of its mission. Practical theology is critical and constructive reflection on the praxis of the Christian community's life and work in its various dimensions.*

Fowler goes further to show that practical theology investigates Scripture and the tradition, on the one hand, and the shape of the ecclesiastical ministry, on the other, for the sake of constructive and critical guidance of the church's praxis. He argues that practical theology aims at a kind of knowing that guides being and doing. Both Farley (1983:21-41), in the article "Theology and practice outside the clerical paradigm", and Fowler agree on anchoring practical theology as critical reflection on the praxis of the Christian community's life and work in its various dimensions, e.g. caring for the poor or HIV/AIDS and death counselling.

Browning (1983:1-18), in introducing the book *Practical Theology: The Emerging Field in Theology, Church and World*, which is a collection of incisive chapters by various authors, outlines core practical theology issues in agreement with other theologians. Burkhart (1983:42-60) outlines Schleiemacher's vision of theology; Farley (1983:42-57) discusses the history of the various forms that theology has taken, with the implicit aim of locating the current practical theology locus; Tracy (1983:61-82) and Ogletree (1983:83-101) state in explicit terms both the organisation of theology and the place of practical theology within it. McCann (1983:105-125) criticises the tendency of letting Marxist theories pervert practical theological thinking, and Lapsley (1983:167-186) devotes himself to delineating the relationship of pastoral theology to theological ethics. All these authors, though their focus differs, in one way or the other underscore the same idea that practical theology is empirical. It implies action with underlying theory. Louw (1998:87), in considering an empirical approach to practical theology, however, warns of the twin pitfalls of this approach, namely the domination of theory over practice and the domination of empirical research over theory; hence he opts for a dialectical spiral model.<sup>2</sup>

Heitink (1993:6) in *Practical Theology: History, Theory, Action Domains* provides an insightful and compound definition of practical theology as a theory of action. He states that it is "the empirically oriented theological theory of the mediation of the Christian faith in the praxis of modern society". Heitink, like Louw, is critical of the coined term "empirical" theology by Van

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<sup>2</sup> For detailed discussion see Louw's *Pastoral Hermeneutics of Care and Encounter* (1998:88).

der Ven (1990), and prefers “practical” theology. He argues that “empirical” denotes or embodies just one of the approaches of the discipline.

But even though Heitink prefers the word “practical”, he uses the term with caution, since it is also open to misunderstanding.

*This happens when practical is seen as the opposite of theoretical, since theory is the opposite of practice. But this branch of theology is not just practical, in the sense that it deals only with actual practice, rather, just like other subdisciplines, it also attempts to share in the development of theological theory in general (1993:7).*

Heitink further states that “Another objection against the term practical theology is that it says little about the unique object and the theological character of this discipline” (1993:7). The object is the theory of praxis.<sup>3</sup> But he agrees with other practical theologians that practical theology deals with God’s activity through the ministry of human beings (i.e. the church).

However, focusing on Heitink’s definition, three issues surface. Practical theology is an empirically oriented theological theory; mediation of Christian faith; and praxis of modern society. By empirically oriented theological theory, he refers to practical theology as one that chooses its point of departure in the experience of human beings and in the current state of the church and society, characterised by a methodology that takes empirical data with utter seriousness, takes these as its starting point and keeps them in mind as it develops its theory. This manner of doing theology differs from exegetical, historical, or philosophical approaches, which are distinctive for other subjects, even though practical theology does use exegetical, systematic and historical methods (Heitink 1993:7).

Heitink calls the mediation of the Christian faith “praxis 1” ‘in’ the praxis of modern society “praxis 2”. Praxis 1 indicates that the unique object of practical theology is related to intentional, more specifically, intermediary or meditative, actions with a view to changing a given situation through agogics. In so saying, he means that God’s action mediated through human action (through faith community) is the centre of practical theology. Praxis 1 underlines that the continuity of the Christian faith in the lives of men and women in the church depends on tradition, and the mediation of the tradition through various channels, e.g. in the church, home and school. The mediation takes shape in forms of communicative action, that is, in communication processes that occur

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<sup>3</sup> **Theory** is understood as a comprehensive hermeneutical-theological statement that relates the Christian tradition to experience, to the life and actions of modern humans. **Praxis** is understood as the actions of individuals and groups in society, within and outside the church, who are willing to be inspired in their private and public lives by the Christian tradition, and who want to focus on the salvation of human kind and the world (Heitink 1993:151).

within specific structures. Practical theology then studies how these processes take place, how these structures can be so adapted that there can be a real transmission of the Christian tradition. Hence praxis 1 has to do with equipping.

Praxis 2 (the praxis of modern society) describes and explains society as praxis, as a domain of action; here individuals and groups, motivated by their personal ideals and driven by varying interests, make specific choices and pursue specific goals. This takes place in the public arena of life, e.g. interactions at work. In this sphere people do intentional actions with ethical implications regardless of their worldview.

Praxis 1 and praxis 2 are joined by the word 'in'. Though theology first of all focuses on praxis 1 (faith community), it is always linked to praxis 2 (wider community) as the case in empirical practical theological research. The two are closely linked. For instance, praxis 1 - the church is empowered by the Word and Spirit in worship and when one is in the community (praxis 2) the radiance is evident. Hence praxis 1 and praxis 2 are intricately linked.

Heitink's definition and description of practical theology as an empirically oriented theological theory, praxis 1 and praxis 2, in which the two praxis concepts are joined by 'in', reveal an ongoing challenge in merging theory and praxis. There is agreement among scholars that Scripture is the normative source of theory (Dingemans 1996). But how, then, is the normative source and people's existential horizon merged? Burger's research (1988, cited by Louw 1998) on the role of practical theology in South Africa identified three basic approaches, i.e. confessional, where Scripture is the only source of knowledge; interactive, linking gospel insights to empirical insights from secular sciences; and contextual, linking the situation and aiming to generate transformation by means of situation analysis. It seems apparent that Burger's observation is useful, though the focal thrust may differ depending on the practical theological paradigm<sup>4</sup> adopted.

Ballard and Pritchard (1996:10-12), in attempting to underpin the contentious issues in practical theology, define the term theology and then use the definition as a measure to unravel the broad task of practical theology. Louw (1998:95-98), after surveying the terrain of practical theology, adopts a similar approach before summarising the developments in the discipline. Louw's definition embraces Fowler's mentioned earlier and it also aligns and clarifies the other definitions. He defined theology as:

*Human reflection (systematic and exegetical reasoning) and interpretation (by means of faith) of the meaning of the covenantal*

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<sup>4</sup> Dingemans (1996), Ballard and Pritchard (1996) and other scholars identified the following as some practical theology paradigms: clerical paradigm, the church paradigm, the liberation paradigm and the individual paradigm.

*encounter between God and human kind as revealed in Scripture. It also reflects on the implications that this encounter has for being a church (ecclesial dimension); for being human (existential dimension); as well as for the eventual destiny of creation (cosmic dimension) (Louw 1998:95).*

This definition, he adds, has an important implication for both practical and pastoral theology. It views theology as a hermeneutical event, involving human reflection and interpretation. Therefore, in light of the definition of theology,

*Practical theology is the hermeneutic of God's encounter with human beings and their world. This encounter results in communicative faith actions. Thus the reason why the praxis of the Christian faith and the practice of the church became the object of research in practical theology (1998:95).*

Louw arrived at this definitional conclusion, as mentioned earlier, after surveying developments in the field. Therefore, considering the previous attempts to underpin practical theology, the developments systematically outlined by Louw (1998:95-97) may illuminate the discussion. Practical theology has developed in various phases.

- ∞ A personality-oriented model. This involved the development of priests' spirituality and the deepening of piety by means of faith exercises.
- ∞ The official model, which developed much later. This model implied the development of clerical offices and focused on establishing the church as an institution.
- ∞ The so-called application model. This implemented Schleiermacher's development of ministry techniques. Theology is applied within the context of religious experiences. This development, which developed parallel to the official model in reformed circles, gradually evolved into
- ∞ An empirical model. The understanding of dialogue as communication, when used in conjunction with other human sciences, compelled practical theology to use the phenomenological method and to focus on human behaviour (so-called communicative actions).
- ∞ A phenomenological model eventually leads to the praxis model. Situation analysis forms the important methodological framework of this model. Osmer (1990:221) describes the problem with this development as: "an over-reliance on the social sciences as a source of substantive theological reflection".

If practical theology is to be brought back to its fundamental theological character, then it should be made aware of its primary function: "That task is the reflective dimension of piety - the attempt to understand God and the

world in relation to God" (1990:225). Practical theology thus becomes a hermeneutical event, involved with understanding and interpreting the God-human interaction. "In short, practical theological reflection is an interpretive process which takes place in the midst of the situations and seeks to understand and shape those situations according to the discernment of God's will" (Osmer 1990:227).

- ✧ A last development should be mentioned. It may be called the ecclesiological model. This is currently popular in many Reformed circles. In this model the function of practical theology is regarded increasingly in terms of the edification of the church. The focal point is not the offices of clerics, as it was in the official model, but the structure of the congregation and the development of *koinonia*. The empirical model is the method used for congregational analysis.
- ✧ To help practical theology to retain its theological character, we choose the hermeneutical model. The hermeneutical model has a theological character when the object of practical theology is not communicative faith actions, but rather understanding the meaning and significance of the covenantal encounter. The primary object of practical theology becomes the praxis of God, the ecclesial structure of the God - human interaction and the meaning of the Christian faith for human actions in the world. Practical theology cannot ignore the praxis of God as exercised through the ministry of the church. This does not mean that we opt for the traditional model, but it implies an ecclesiological approach. The focal point in this approach is the ministry, the development of spirituality and the transformation of people and the world. The Spirit is the most important factor in this process of transformation. Practical theology, therefore, is linked to the eschatological perspective as exercised through the Spirit.

Louw sums his analysis of the developments by stating that practical theology is determined by:

- ✧ The method of correlation which operates with a bipolar principle;
- ✧ A hermeneutics which deals both with the presence of God and the context of humanity;
- ✧ The praxis of God with the Spirit as mediating agent;
- ✧ The dynamics of theory and praxis within a spiral model;
- ✧ A process of understanding and interpretation which operates contextually and systematically;
- ✧ The ministry and practice of the church (ecclesial practices) in the world;
- ✧ The dynamics of the encounter between God and human kind viewed from the perspective of faith - the meaning dimension of the Christian faith.



From Louw's practical theology outline, it is clear that the later models emphasise an ecclesiological approach, which is crucial for addressing poverty and HIV/AIDS. However, to understand our being the church within the dynamics of contextuality, interculturality and communal issues, i.e. a shift from the clerical paradigm to a systems paradigm translated into ecclesiological terminology, Moltmann (1993:311ff) argues for the notion of the church as base communities that he calls "grassroots" communities. The characteristics of such communities are:

- ≈ The voluntary association of members in a Christian fellowship;
- ≈ The fellowship of a manageable size, in which life in mutual friendship and common devotion to a specific task is possible;
- ≈ The awakening of creative powers in every individual and the surrender of privileges that members bring with them;
- ≈ Autonomy in forming the spiritual life of the community and its life of fellowship;
- ≈ Common concentration on special Christian tasks in society, whether it be the field of evangelisation, or the liberation of the under-privileged and oppressed;
- ≈ The deliberate return to a simple Christocentric approach in the devotional life and a reflection of new Christian practice in theology (Moltmann 1993:329).

These grassroots communities, Moltmann argues, are a prophetic leaven for the renewal of the church and society. They live the simple communion of saints or fellowship of believers in a convincing way through open friendship among the people. They entail inclusivity of congregation members (*koinonia*) and mutual care and service (*diakonia*). Moltmann (1993:331) added that "the concept of community is a term for a process, in the course of which a community determines its needs and goals, orders them, or brings them into sequence of priorities; develops the confidence and the will to do something about them".

Moltmann's ecclesiological emphasis, hinging on base communities termed grassroots communities, highlights the central role of the *koninoia* function. He further argues for the church as a kingdom of God that is influenced by the Holy Spirit. As such, the church as messianic people is destined for the coming kingdom (future), which influences its practices. The ecclesiological practices are not an end in themselves, but the "being the church" waiting for consummation.

Thus in our pursuit of a practical theological ecclesiology, Moltmann's reasoning and the hermeneutical model proposed by Louw resolve the issues that make us wary in doing practical theology, namely, making praxis the end

and uncritical integration of theology with social sciences. Fowler (1983:165) highlights the same danger also that:

*There is danger in identifying practical theology with the ethical, at the expense of Holy Awe before the Mysterium Tremendum. In our concern for public language and for rational foundations for our theologies, let us not underestimate the archetypical and historical power of the cross and resurrection, the universal longing for the Messiah (italics my own emphasis), and the deep rationality of our response, in kind, to a universal love.*

Ogletree (1983:83-101), arguably making a representative statement on behalf of many others, avoids an uncritical mix of social sciences with practical theology by describing their role as that of surfacing dynamics that constrain and channel our action. The question we may pose at this juncture, however, is: what advantage, then, does the hermeneutical model has over the other models of doing practical theology?

The intrinsic value of the hermeneutical model is that it clearly points the end of practical theology, i.e. transformation of people and the world, which has ethical implications of preserving human dignity. At the same time it recognises the tension, i.e. bipolarity, between the social sciences and theology. The tension, he argues, is a healthy one. These two issues (social sciences and theology) are linked by the eschatological perspective through the Holy Spirit. The unique role of the Holy Spirit in concretising the expression of God's praxis in terms of hermeneutics (the clarity and truth of eschatological perspective), agogy (the Holy Spirit's influencing, changing and renewing work), and *diakonia* (mediating salvation via ecclesial services, i.e. social ministry) is central in the hermeneutical model. The Holy Spirit influences the three spheres of human beings (i.e. the church). Thus practical theology as hermeneutics involves the interpretation of the meaning of the interaction between God and humanity, the edification of the church and becoming engaged in praxis through communities of faith, which Moltmann (1993) calls grassroots communities, in order to transform the world or impart meaning in life. It focuses on interpreting the meaning of salvation so that it concretises faith. It tries to interpret and translate the praxis of God in terms of existential issues through the action of faith communities – the ministry of the church in the world.

To wrap up the discussion, therefore, I should underline that practical theology is concerned with theory/reflection and praxis/action. It is the empirically oriented theological theory of the mediation of the Christian faith in the praxis of society. It has three main components that demarcate it: the community of faith and its belief; interpretation and communication; modification and transformation as ministerial. Thus practical theology is *fides quaerens*

*intellectum* (faith seeking ways of understanding); *fides quaerens verbum* (faith seeking ways of conversing and communication); and *fides quaerens actum* (faith seeking ways of appropriate action and doing), under the Holy Spirit's influence. However, to avoid the pitfall of making praxis or action the end of practical theology, a hermeneutical model should be adopted. A hermeneutical model implies an ecclesiological approach, which focuses on ministry – the development of spirituality and the transformation of people and the world. This means that whatever acts of mercy that people do are not an end in themselves, but are performed to help people become reconciled to God, who is the ultimate solution to humanity's problems. However, the question I should pose at this point is: what implications does this practical theological approach have for the poor and HIV/AIDS-affected people?

The discipline of practical theology, as argued, is concerned with concretising salvation through faith communities (the church). In order to fully utilise or harness the faith community's (*koinonia*) caring potential we have opted for a hermeneutical approach. It focuses on the ministry of the church (*koinonia*). Focusing on the church's "grassroots" communities encourages community participation (a bottom-up approach). Moltmann (1993:331) rightly points out that the concept of community entails that community people determine their needs and goals, and order them, or bring them into sequence. Our preference for such an approach is in accordance with the complex nature of the interplay between poverty and HIV/AIDS (cf. Chapter 3; Louw 2003:209; Vos 2003:233). It requires people who are immersed in the context in order to appropriately intervene of which the church is. This implies that, as church members become empowered by the Spirit, they become transforming agents through their involvement with the poor and HIV/AIDS-infected people.

The contribution of the hermeneutical model of practical theology, therefore, is that it emphasises faith community (*koinonia*) involvement (ministry). It focuses on the ecclesial structure of the God-human interaction and the meaning of the Christian faith for human actions in the world. This implies an ecclesiological approach with a focus on the ministry, spirituality and the transformation of people. Thus faith community members, as eschatological beings, are driven by the Spirit to be caring beings. However, to challenge church members to do this requires a theological basis. Therefore I should ask: is there a theological principle/basis for such an ecclesiological (*koinonia*) approach that can be discerned in Scripture? In response to this question, I suggest the family as metaphor for a re-interpretation of our being the church.

### 4.3 Towards a Theological Interpretation of Family

#### 4.3.1 A reassessment of ecclesiology: Family in Scripture

The word family is difficult to sum up succinctly. It has different meaning to different people. To a Westerner it may only refer to a nuclear family (i.e. husband and wife and few children, if any), while to an African, it may refer to a cluster (i.e. extended family) of nuclear families. The *Chambers Etymological English Dictionary* defines family as “the household, or all those who live in one house (as parents, children, servant); parents and their children: the children alone: the descendants of one common progenitor” (Macdonald 1967:222). Kayongo-Male and Onyango (1991:11-12) and Hunter (2001:70), however, described a family at its simplest level as husband and wife and their offspring, which is called the nuclear family. When children and their children’s children live together, it is called extended family.

In terms of classifying a family, Montgomery and Fewer (1988:95) state that it should have the following characteristics: (1) be legally recognised as a family, (2) be generally recognised in our society as an acceptable family form, (3) members see themselves as a family, (4) meets members’ intimacy needs and fulfils the other functions prescribed by society, and (5) be lifelong or at least the members expect permanence. The nuclear family of contemporary society with its once-married mother and father and their dependent children clearly fits into the family category. But can this definition include the extended family?

Following the characteristics of the family highlighted above, we would argue that the African extended family fits this description. Though the marriage oaths are sometimes not performed in the modern legal system (i.e. an oath before a government official), the community legally views them as a family and ascribes to them full societal status of family. They (the married people) also absolutely believe that they are married, fulfil societal family functions, and are permanently bonded. In line with this thinking of family, according to the Zimbabwean law (and other parts of the world hopefully), any woman who lives with a man and bears children with him, despite not having a marriage certificate, has full marriage rights in case of divorce (or separation).

In Africa the extended family is the common form of family. Husband and wife, children and grandchildren, nephews and nieces, aunts and uncles all form part of the family. However, Kayongo-Male and Onyango’s (1991:11-12) designation of the extended family – that it exists when children and their children’s children live together – can be misleading. People don’t necessarily have to live together, especially in modern times. They may live 50 kilometres apart or even in far away cities, but be still very much connected. Though this variation weakens the extended family bond, it still retains most of the

functions of the extended family. It is an extended family adaptation mechanism due to economic changes and land shortage. In Zimbabwe this phenomenon is growing exponentially, especially with the land redistribution and resettlement in the last five to six years. But the strength of the extended family bond is still very much discerned. People don't consider themselves as isolated, but think in terms of the whole extended family.

In Hebrew the word "family" is used to translate several words, none of which means exactly what family means in modern Western usage (Wright 1992:761). Their understanding of family shares a lot of similarities with the African extended family (discussion later). The three primary units of social organisation shaped by kinship structures that are associated with family are the *sebet/matteh* (i.e. tribe), the *mispahah* (i.e. clan), and the *bet 'ab* (i.e. father's house or household) (Wilson 1985:302; Nunnally 2000:457).

*The sebet/matteh (tribe):* The *sebet/matteh* refers to a larger social unit that provided the major geographic and kinship organisation for ancient Israel (Wright 1992:761; Perdue 1997:17; White 1975:497). Israel consisted of twelve tribes named after one household (Jacob) that included the two sons of Joseph, i.e. Ephraim and Manasseh. The tribe combined real and fictional structures for clans and households, provided a judicial council for settling disputes between clans, spoke the same language, shared traditions and practices of law and custom, practised a common religion, and offered the means for mustering a citizen militia for protection (Perdue 1997:17; Wright 1992:761).

*The mispahah (clan):* *Mispahah* is a difficult word to translate. English versions (e.g. RSV) render it as "family", which Wright (1992:761) argues is misleading, since the *mispahah* could be comprised of quite a large number of families. It was a unit of kinship, but of a wider scope than the English word family. Its most specific meaning is a residential kinship group of several families or, more commonly, a clan (Perdue 1997:177). The *mispahah* was distinctively a unit of recognisable kinship as seen on the census lists (Numbers 1 and 26). It is also known for its territorial identity (e.g. Joshua 13-19, when Joshua was allotting the land). Thus, the *mispahah* consisted of farm households related by kinship and marriage, clans held together by language, economic cooperation, shared traditions of law and custom, ancestral stories and a common religion. Wright's (1992:762) comment about *mispahah* sums it up: when an Israelite gave his full name including his house, clan, and tribe, it not only stated his kinship network but practically served as a geographical address as well. This was so because of *mispahah's* territorial attachment.

*The bet 'ab (father's house or household):* The Hebrew word *bayit* means house and *'ab* means father. Literally, therefore, *bet 'ab* means "house of the father" and is commonly rendered "father's house". This was the third level of the kinship structure of Israel and the one in which the individual Israelite felt the

strongest sense of inclusion, identity, protection and responsibility (Wright 1992:762; Perdue 1997:175). In the same light, Perdue (1997:175) added that in view of the literary and archaeological evidence, these terms are best rendered as family household and extended or compound family. He further states that family households did not consist of nuclear families, as in the modern understanding of married couple and their children, but rather were multigenerational (up to four generations) and included the social arrangement of several families, related by blood and marriage, who lived in two or three houses architecturally connected. The people belonging to the family household are mentioned many times in the Old Testament (e.g. Gen 36:6; 45:10; Ex 20:8-10; Josh 7:16-18; Judg 6:11, 27, 30; 8:20).

Many Old Testament scholars (e.g. Nunnally 2000:457; Wilson 1985:302; White 1975:497; Strahan 1912:724; Perdue 1997:175) agree with Wright's (1992:762) underpinning of *bet 'ab* that the father's house was an extended family, comprising all the descendents of a single living ancestor (the head, i.e. *ros-bet*) in a single lineage, excluding married daughters (who entered their husbands *bet 'ab* along with their families), male and female slaves and their families, resident labourers, and sometimes resident Levites. Thus, the *bet 'ab* included the head of the household and his wife (or wives), his sons and their wives, plus any unmarried sons or daughters in the generations below him, along with all the non-related dependants. The *bet 'ab* could have been comprised of some fifty to hundred persons residing in a cluster of dwellings. Meyers (1997:19) further explained that the *bet 'ab* denotes the extended family that inhabited a residential unit of several linked dwellings. The *bet 'ab*'s setting created an environment where the family (extended) had closer knowledge of what is transpiring in the next dwelling, which allowed for swift care intervention. In case of orphans, it was easy to integrate them, since they were already part of the *bet 'ab* system.

To illustrate the *sebet*, *mispahah*, and *bet 'ab* more clearly, let us consider the incident of the Israelites' defeat at Ai because of Achan's sin (Joshua 7). In searching for the perpetrator, it narrowed down from tribe (*sebet*) to clan (*mispahah*) to the family (*bet 'ab*) and finally to the individual, Achan. These three major social units are then repeated in reverse order when his full name is given: Achan son of Carmi (his own father's name), the son of Zimri (*bet 'ab*), the son of Zerah (*mispahah*) of the tribe of Judah (*sebet*) (Joshua 7:18). Therefore, when one speaks of the Old Testament or Jewish family, one will be referring to the *bet 'ab*. But how was life lived within the *bet 'ab*?

Our discussion of family above focused on the family as a household unit. The discussion revealed that the word "family" might have different meanings to different people. Perdue (1997:165), in agreeing with Meyers (1997:19-21), rightly states that family is a deceptively simple English word that masks a unit of social connection and interaction that is incredibly complex and varied. It is

complex and diverse even in the same culture. But family refers to both nuclear and extended, according to the characteristics given by Montgomery and Fewer (1988:95). In Africa, though there may be a focus on the nuclear family, the extended family is dominant. Family members may live separately, but are still very much connected. This is evident during family ceremonies and crises, when they converge to do things together. In Hebrew the *bet 'ab* denotes family much in the same sense we understand the word and is very similar to the African extended family.

The description of family above focused on the family unit, but it is important to note that the word family is used metaphorically in Scripture (New Testament).

#### **4.3.2 Church as family: a metaphorical approach**

Metaphors, Louw (2000:49) states, are used as a figure of speech in the theological vocabulary to present, comprehensibly and meaningfully, the unknown (revelation) in terms of the known (creation). It is an attempt to take the meaning dimension of God-languages and contexts seriously. Its objective is to understand the process of naming God in terms of real-life issues. Metaphorical theology enhances the dynamic interplay between God and existential events. Hence it is likely that the apathy and indifference that some church people display to one another and to outsiders (society) may be largely due to poor understanding of the rich metaphors in Scripture about the church. If Christians fully understand and embody these metaphors, they would not be indifferent to the plight of the poor and HIV/AIDS-affected people among them and around them. However, the challenge is to identify these metaphors and choose the appropriate one for the context.

To help us understand the nature of the church (ecclesiology), Scripture<sup>5</sup> uses a wide range of metaphors and images to describe what the church is like. Some of the metaphors or images that can be identified in Scripture are church as:

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<sup>5</sup> Scripture should be used contextually not homiletically. The methodology used in contextual usage of Scripture is not to take a specific theme or text and apply it to the situation, but first to listen and identify the problem. However, in the usage of Scripture one should be aware of the dynamic nature, intention and authority of Scripture. Berkof (1985:84) rightly comments that:

The validity, which came to the first witnesses in the cultural forms and thought modes of their situation, needs to be passed on to succeeding generations in their situation. But that has to be a genuine interpretation and transmission of the past events, not a transmission and adaptation to the new situation in which the uniqueness, the revelational dimension of earlier happenings, is swallowed up by and lost in the ongoing stream of history. This evokes a double need in the following generations that want to live from the earlier revelational events: on the one hand, to fixate these events in a way which protects them against fading and misrepresentation; and on the other hand, to throw fresh light on and to articulate, perhaps also in the light of later revelational events, for the times to come these fixated events. Only so does each new present get an encounter with the eternity dimension of an earlier revelational event.

family, kingdom of God, bride of Christ (2 Cor. 11:2; Eph 5:22-32), body of Christ (1 Cor 12:12-27), Zion (Rev 21:2), and temple (1 Cor 6:19). In other metaphors Scripture compares the church to branches on a vine (Jn 15:5), an olive tree (Rom 11:17-24), a field of crops (1 Cor 3:6-9), a building (1 Cor 3:9), and a harvest (Matt. 13:1-30) (Hill 1988:188-189; Grudem 1994:858-859).<sup>6</sup> These metaphors will not be discussed, except church as family, which is the focus of this research. However, lessons will be drawn from the different metaphors where necessary.

Christians (church members) can effectively live as conduits of God's kingdom by embodying the family metaphor. Paul views the church as a family when he tells Timothy to act as if all the church members were members of a larger family: "Do not rebuke an older man but exhort him as you would a father, treat young men like brothers, older women like mothers, young women like sisters" (1 Tim. 5:1-2). God is our heavenly Father (Eph. 3:14), and we are his sons and daughters, for God says to us, "I will be a father to you, and you shall be my sons and daughters, says the Lord Almighty" (2 Cor. 6:18). "We are therefore brothers and sisters with each other in God's family" (Matt 12:49-50; 1 Jn 3:14-18) (Grudem 1994:858).

However, to draw sound conclusions that the church is a family (metaphor), which leads to a sound ecclesiological derivation, requires considering the role that the biological family played until the emergence of the nation Israel and the church. Ryken (1998:264) maintains that the Bible begins with the biological family as the central social context of human life and as a chief means of God's communication with human beings. This social view of the family becomes extended into a spiritual reality and heavenly reality, with the community of God's people as a metaphoric family.

Ryken (1998) further argues that stories about families not nations dominate the book of Genesis. The history narrated is a succession of family narratives – Adam and Eve, Noah, Abraham, Lot, Isaac and Jacob. The book of Ruth, among others, is also focused on the family and family relationships. Ryken (1998:264) observes that with the exodus and the monarchy the focus becomes more public, but even here the stories about national leaders seldom lose sight of the domestic lives of people – Moses is a leader but also a brother, husband and father; David, filling the roles of son, brother, husband and father, is a family man; Job's family history of personal suffering takes place in the context of family, etc. The New Testament gives fewer stories about families, but there are glimpses of families in miracles involving children, domestic scenes of Jesus' visits to the homes of Mary, Martha and Lazarus. Family scenes are numerous in Acts, where scenes of preaching, conversion and baptism sometimes include family unit (e.g. Acts 16).

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<sup>6</sup> For detailed discussion of church metaphors see Grudem (1994) and Hill (1988).



The other dimension in which family is presented is the general procreation of the human race to perpetuate itself (Gen. 1:27) and in all the patriarchal narratives. In Genesis also there is a picture of family as the main social context within which people live their lives. It shows life at its primal social level, with stories of squabbling spouses and siblings, but with a message of hope. It is the family unit through which God perpetuates his covenant (Noah's family Gen. 9 and Abraham's family Gen 12). Thus, despite family disappointment and struggle, on the one hand, it is a sign of hope and blessing, on the other hand.

The covenants of God with the patriarchs are stories of blessing to families and descendants, generation after generation. God worked through Abraham's family as he promised – through the generations to King David and through more generations to Jesus Christ. In Jesus, however, the channel narrowed to one brilliant point and then burst forward into a wide stream. Psalm 22 pictures the huge throng of people “from all the earth” who will worship God: “All the families of the nations will bow down before him” Ps. 22:27). This picture of all the families of the nations worshipping the Christ is the glorious end toward which all the generations are moving.

In the meantime, in any particular generation somewhere between the beginning and the end, God consistently channels his grace and justice through family units, however large or small, e.g. Passover (Ex. 12:3), Rahab (Jos. 6:23), etc. In the New Testament God reached into whole family units, e.g. Cornelius (Acts 11:14), Paul and the Jailer, and Lydia in Philippi (Acts 16). Thus on a different note to family as a biological unit, the family is the unit through which God perpetuates his blessings.

The Bible also presents to us a picture of a human redeemed family. It is reconciled and harmonious (Mal 4:6), secondly, it should be ordered and not random household codes (Eph. 5:22-6:4; Col 3:18-21), and thirdly, the redeemed family is compassionate and members care for one another. Jesus castigated the Pharisees for not supporting their parents (Matt. 15:4-6), and Paul encourages Timothy that people should put their religion into practice by caring for their family (1 Tim 5:4,8).

Another strand of family in Scripture is that of spiritual reality. The Jews took God's covenant with Abraham seriously to heart. They knew that they were in his family as it continued through generations. However, when the blessing came in the form of Jesus, he challenged them to look through the earthly family to see the heavenly one. “If you are Abraham's children then you would do the things Abraham did” (Jn 8:39). Jesus points the Jews to the God who must be their Father, and to himself as the one who can show the way to the Father (Jn 8:42). Jesus points to the spiritual family, the family of God. When his mother and brothers were looking for him, Jesus asked, “Who is my

mother, and who are my brothers?" (Matt. 12:48-49). Jesus then pointed to his disciples and said, whoever does the will of the Father in heaven are his true brother, sister and mother.

The heavenly family is eternal, while the earthly one is temporary. In fact, the heavenly family takes precedence to an extent that one must turn against his father, daughter, or mother (Matt. 10:35ff) in households where conflict arises between the eternal heavenly Father and the earthly father. The coming of Jesus makes the call much more concrete, but in effect this call to love God and be part of his family is the same call that came to Abraham, the father who loved God more than his son Isaac (Gen. 22). God made Abraham to be the physical father of many nations and at the same time the spiritual father of those who have faith like his in the heavenly Father (Gal. 3:7). The book of Hebrews develops Christ's picture of his brotherhood and sisterhood with all believers, who belong to "the same family" with the one who "had to be made like his brothers (and sisters inclusive) in every way" in order to make perfect atonement for their sin (Hebrew 2:11,17). The "family of believers" (Gal. 6:10), or "the family of God" (1Pet. 4:17) becomes a familiar picture in New Testament teaching. Both Jews and Gentiles are members of God's household (Eph. 2:19). The church therefore in the New Testament is described as a spiritual family, which I shall call family or church family in this research.

However, though the *bet 'ab* and the spiritual family may rightly be called a family, regarding my attempt to come up with a practical ecclesiology that is responsive to the poverty and HIV/AIDS scenario, I ask the following question: what are the functions (roles) of family members in such a setting that may contribute to effective ecclesiological caring function? To respond to this question, I consider family in terms of system and functions. The members, as part of a system, have functions.

#### **4.3.3 *Bet 'ab*: the spirituality of family life**

Montgomery and Fewer (1988:94), in *Family System and Beyond*, call family a system. A system is a collection of interrelated components and the existing relationships among the components. The family as a system, therefore, is a collection of people whose behaviour is interrelated in a particular way and the relationships that exist among these people. Montgomery and Fewer (1988:94) further explained that for a group to be classified as a family, it must be legally or socially, or internally, defined as a family and its interaction must have certain characteristics (as discussed earlier). The interaction within a family results from the members' attempt to fulfil major functions. For instance, say, in rural Zimbabwe the father and son go to hunt, while the mother and daughter do the household chores. When the father and son return, they skin the animal, while the mother and daughter prepare a meal. In so doing, family

members are performing their functions within the system. And the extended family is an extension of the nuclear family. The extended family members, much like the Jewish *bet 'ab*, were able to provide effective care for one another through communality. But what precisely were the *bet 'ab* and the spiritual family's caring functions?

*In the bet 'ab (Old Testament – Jewish) family system, we should firstly consider family identity. Life within the bet 'ab was communal. Family identity was embedded in the family as a group (Meyers 1997:21). An individual derived identity from his/her contribution to household survival rather than from individual accomplishment. The profound interdependence of family members in self-sufficient agrarian families created an atmosphere of corporate family identity, in which one could conceive not of personal goals and ventures, but only of familial ones. The merging of the self with family led one to observe a collective, group-oriented mindset, with the welfare of the individual inseparable from that of the living group. Meyers (1997: 21-22) succinctly put it as follows:*

*Family life was not distinct from whatever roles, prescribed according to age and gender, that individual members may have played. Work and family were not independent spheres just as property and family were not independent entities. The family as a residential, landed group was a collectivity, with its corporate goals and fortunes valued above the welfare of any of its constituent members... A person was not an autonomous entity but someone's father, mother, daughter, son, grandparent, and so forth.*

Hence, it was easy to erect societal caring structures, since each person perceived him/herself in light of the other person (system) (detailed discussion of this aspect later).

Secondly, *skill continuity*. In the Israelite family the function or activity of each person<sup>7</sup> was geared towards family continuity, i.e. economics (production and consumption), reproduction, nurture, education, military and judiciary (Meyers 1997:23; Perdue 1997:168-174).

Thirdly, *economic*. The whole family provided the labour for food production, which was subsistence farming (Blenkinsopp 1997:57). However, there was also division of labour. Men cleared the thick forests, while women cultivated near the house. But harvesting was a combined effort of men and women. Meyers (1997:25) warns that the tendency for women to be near the house does not suggest that they performed only the easy tasks. Cereal, which was the major

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<sup>7</sup> Scholars such as Phillipe Aries (cited by Blenkinsopp 1997:66) argues that for most of recorded history, in most cultures, small children – minors – were practically invisible; where they appear in literature and image, they are represented as scaled-down adults. Hence, often men includes boys and women includes girls.

food, required a series of operations to prepare. This also allowed for women to care for young children and gardens. These tasks were equally time consuming. Furthermore, women's tasks required a higher degree of expertise, judgment and skill than male tasks did.

Fourthly, *reproduction and education*. Procreation was part of supplying labour and maintaining land tenure in ancient Israel (Meyers 1997:30). This could be seen in the educative/socialisation dimension of the family, which was primarily the responsibility of the parents, especially the father (Prov 4:1-9) (Collins 1997:141).

During interactions where skills and procedures were transmitted, the interconnection of production and reproduction was reflected. Senior males taught young males skills such as making the appropriate crop choices, livestock management and soil-type observations as they were apprenticed to be fathers. On the other side, older women taught younger women skills such as technical aspects of gardening, food processing, textile production and raising siblings. Besides skills for economic purposes, the young men were taught religious rituals, standards of interpersonal and family behaviour, legal regulations and morality. This enabled transmission of norms and values from one generation to the next.

While it is important to discuss the judicial and military aspects of the family, they will not be discussed here, because they are outside the relevant scope of this research. Only the families' nurturing aspect shall be discussed.

*Old Testament: (Jewish) Family care:* In the above discussion, the Israelite family system was considered in the light of various aspects excluding family care. Concurring with Perdue (1997:192), it is crucially significant for our subject of caring for the poor and HIV/AIDS-affected people, to highlight that the household, i.e. *bet 'ab*, in ancient Israel and early Judaism provided the primary care for its members, both for those who belonged to the kinship and marriage structure and for the resident marginals. This system of care was augmented by household acts of charity on behalf of the poor, who did not enjoy the nurture and support of their own households. Israel was a society that protected and cared for its poor.

The Israelites had the following structures in their family to care for the needs of the people: the redeemer, child care, widow care, divorced women care, the sick and the aged care, debt servants and slaves, resident alien care, sojourner care, hired labour care, and care for the poor outside the household (Perdue 1997:192-202). However, though it may be worthwhile to discuss all these caring structures, for the sake of relevance to HIV/AIDS home-based care, only child care, care for the sick and the aged, and care for the widows and the poor will be discussed. In fact, our special interest lies in child care and care for the

sick and aged, which has direct relevance to HIV/AIDS home care – the former for HIV/AIDS orphan care and the latter for the HIV/ADS- affected people.

*Child care (the fatherless):* The children were nurtured by members of the household (*bet 'ab*). From birth the children received care from their parents and other (extended family) household members, until they could contribute towards performing the tasks of the family themselves.

The household also offered care to the fatherless, i.e. children from broken families that no longer provided nurture and protection. There is some debate about whether the fatherless refers to orphans without both parents or without fathers only. In this regard, Perdue's (1997:193) suggestion that the latter is most likely to be correct is consistent with the Old Testament case. The father was the key person who would shield, protect, negotiate, etc. with elders on behalf of the entire family. Death of the father, therefore, meant lack of protection and vulnerability.

The fatherless are always placed alongside widows in the Bible, suggesting that the poor widows were also supporting children (Job 22:9; 24:3; 29:12-13; Ps 68:6; Is 1:17, 23). Within the kinship structure of the household, the fatherless were incorporated into a new household (Job 31:18; Esther 2:7, 15). Furthermore, the fatherless were protected by law (Deut 27:19). Their rights were to be observed and justice granted to them in court (Ex 22:21-25; Deut 24:17; 27:19; Prov 23:10). They were also supposed to receive support from outside the kinship structure; harvesters. for example, were supposed to leave some crops for them to glean in the fields for their support (Deut 24:19-21). Other rights include receiving tithes (Deut 14:28-29; 26:12) and a share in harvest festivals (Deut 16:9-11).

The fatherless and the other poor were often oppressed and their rights not observed, hence the prophets spoke out for justice on their behalf (Is 1:17, 23; 9:17; 10:1-2; Jer 5:28; Zech 7:10; Mal 3:5). Wisdom literature also supports the just cause and needs of the poor and the fatherless (Job 29:12; 31:17-18; Prov 23:10). Perdue (1997:194) concluded by saying that the fatherless children could remain in their deceased father's house with their widowed mothers and continue to be nurtured within this setting.

*Widow care:* The widow who was childless could remain a member of her husband's family, if a kinsman took her. A son who was produced from the union of the widow and the kinsman redeemer continued the name of the dead husband. If there were no kinsman redeemer, the widow would return to her father's house (Gen 38:11; Lev 22:13; Ruth 1:8). Widows and their children (fatherless) could be in extreme poverty if they had no household to provide support and nurture for them (1 Kings 17:8-15; 2 Kings 4:1-7). The widows, the fatherless, and the Levites also lived within the ambit of charity laws when they had no household care for them (Deut 10:18; 24:17-21; 26:12-13; 27:19).

*The sick and the aged:* Family members largely administered health care as seen in 2 Samuel 13 about Ammon's lustful desires for Tamar, which resulted in his tragic murder by Absalom. The same care system is seen in 1 Kings 17:17. Importantly also, grown children cared for the aged and provided a proper and decent burial for them (Gen 49-50).

*Care for the poor:* Referring to care for the poor, Perdue (1997:200) stated that the household (*bet 'ab*) provided the essential network for the care and nurture of both members who were related by blood and marriages, including grandparents, parents, children, uncles, aunts, nephews, nieces, cousins, widows and the fatherless. This network of protection and sustenance also extended outward to provide some care for the larger associations of clans knit together by kinship and marriage (e.g. Ruth). This social system no doubt provided the means by which care was provided for clan households in distress or that had fragmented.

Charity to the poor was part of Israelite law. The poor *'ebyon* (i.e. those who are destitute and without means to survive, e.g. Ps 35:10; 72:12; 102:16), *dal* (i.e. primarily those who have lost their social status and property e.g. Ex 23:3; 30:15; Lev 14:21), and *'ani* (i.e. those who are victims of oppression e.g. Ps 10:2; Is 3:14; Ezek 18:14-18; Amos 2:7) were supposed to be assisted in various ways in neighbours' fields, to glean, and collect the tithe that was collected in the third year for the destitute (Deut 14:28-29).

However, while the Old Testament has clear teaching on family unity, the New Testament does not discuss this aspect. It focuses on the spiritual family. Thus family usually refers to the spiritual family (believers), i.e. it is a metaphor. The two Greek words *patria* and *oikos* are used to designate the family. *Patria* signifies family from the perspective of historical descent (e.g. Luke 2:4), while *oikos* (house) signifies family as household in much the same way as Hebrew *bayit* in the Old Testament (Wright 1992:768). White (1975:499) drew some similarities between Old Testament and New Testament. He stated that, while the Hellenistic and Roman rulers had enforced a vast stable of princes and princelings, the common people followed the Old Testament family tradition. The father was still the head, the wife concerned with motherhood, and the children were jointly raised by the community.. However, what is significant about the New Testament family system is the inclusion of all people (believers) as one family.

The Old Testament *bet'ab* (household or father's house) was a major feature of the Israelite world, and the *oikos* (household) likewise in the Greco-Roman world. Therefore, it is not surprising that households played a significant role in the growth and character of the early Christian movement. The church in Jerusalem worshipped and was instructed *kat' οικον* (Acts 2:46; 5:42; 12:12). There are many such cases (e.g. Philemon 1ff, Romans 16:23; 1 Cor 16:15; etc.).

Perdue (1997), Wright (1992) and many other scholars agree that the functions of *bet 'ab*, much as in the New Testament, can generally be summed up in three features, i.e. inclusion, authority and spiritual continuity. These features are also present in the household church pattern. It is important to discuss these three functions, but for the sake of relevance to our subject, only inclusion shall be discussed.

*Inclusion:* Paul in Ephesians 2 describes the inclusiveness of the gospel. In his teaching he drew heavily on the kinship language of the Old Testament (Stott 1994:89-92). In Christ, through the cross, the gentiles are no longer “foreigners and aliens” (the equivalent terms to *gerim* and *tosabim*, whose only means of sharing in Israel was to reside within an Israelite household). Rather, they have become members of “God’s household” (a term used to describe Israel), indeed “fellow heirs” (Ephesians 2:19ff; 3:6) (Wright 1992:768). Thus God’s family is bound together by the Christ events (Vos 2003:241).

Therefore, as Vos (2003:239-240) further rightly states, the imagery built in the New Testament springs from the fact that in ancient Mediterranean life, the family was generally seen as the basic social structure, from which the contemporary church may derive lessons. The family imagery plays a key role, especially in John. The ethical attitudes and actions in God’s family are reflected in John’s Gospel by words like “love, knowledge, service, obedience, friendship and honour” (2003:240) [my emphasis]. These ethical attitudes and actions must characterise the family of God in our day (i.e. the church). Thus doing what the Father (God) does (faithfully trying as much as the Spirit enables!). These ethics should become our personal ethics and the ethics of our society. This representation of the divine family provides the building blocks for an ecclesiology that provides mutual care.

Inclusion in the family of God produces strong obligation to one’s “kin” in the faith (congregational or church systems). These social and ethical demands of *koinonia* (fellowship) are prominent in the New Testament (e.g. Acts 2:42, 44; 4:34; Rom 12:13; 15:20ff; Gal 6:6; etc.). Wright further notes that this emphasis on sharing, meeting needs, equality and generosity strongly recalls the economic ethic of the Old Testament and has roots in the household ethos, which should influence our ecclesiological practices. Thus, the household of faith (family of believers - Gal 6:10) has priority in the general command to do good, though there is urging to care for one’s blood relatives (1 Timothy 5:4-8).

Thus far I have argued that the *bet 'ab* extended family played a key role in providing care for one another in the Old Testament. The *bet 'ab* life was about communality. People perceived themselves as a group and not as isolated individuals. Within this group identity skills continuity, economic skills, reproduction and education were passed on from one generation to the next. The various laws that bound them together strengthened this connectivity.

There were laws that governed care for the poor, widows, orphans, and the sick and aged. This communal system approach to care for one another, apart from being reinforced by various laws, was possible because of the interconnection and interdependence that existed among the people. One could not focus on the self “I” but “us”. What affected one member affected the whole group (*bet 'ab* – extended family). *Yahweh* in a way intended this systemic approach to make Israel an exemplary nation.

The New Testament has a vast wealth of familial characteristics that have an Old Testament background. Thus it is not surprising that the early Christians also took over the metaphorical use of family as a picture for the whole church. Wright (1992:769) concluded that Israel could be called *bet Yahweh*, i.e. house/family of God (Num 12:7; Jer 12:7; Hos 8:1), where the temple probably stands for the whole land and people of God. And the church, as the heir and organic continuum of Israel, could be called the *oikos* of God (Ephesians 2:19; Gal 6:10; Heb 3:2-6; 1 Tim 3:15; 1 Pet 4:17). Both in the Old and New Testament, by being part of the family, each member had responsibility for others. Life was not about “I” but “us”.

To summarise my theology of family, within the process of understanding, I should underline that family should be perceived as the church, i.e. family of God (spiritual family) paradigm. Though family is rendered as *bet'ab*, the extended family in the Old Testament, the inclusion of all people in the church (the family of God) takes precedence in the New Testament. We should speak of a bigger family – the family of God, the church. And importantly, the church family like the *bet 'ab*, exerts a challenge on members to think in systemic terms. They should not view themselves as “I” but “us”. Therefore I opt for the church family (i.e. metaphor) as the appropriate and relevant rendering of family that we will refer in this research.

Regarding my ecclesiology driven by the family metaphor, it is clear that Israel and the spiritual family in Scripture provide an example of how people should care for one another. But how does the African extended family compare to this model?

#### **4.3.4 The extended family in Africa: possible links with the family metaphor**

The members of the extended family act as an invaluable buffer in times of crisis and suffering. For instance, within the Magezi extended family (i.e. where the researcher belongs), when serious sickness occurs, the whole extended family converges at that particular home to discuss the best way of resolving the crisis. In the case of death, the extended family spends evenings with the nuclear family within which the death occurred for up to a month comforting them. Elders, women, boys and girls have different functions. Elders sit and



discuss major decisions to be made, boys fetch logs for firewood, girls fetch water from the well and women prepare the food. This, therefore, is an example of the extended family as a functional system with each member fulfilling his/her function.

*Extended family: a solution to crisis:* The extended family plays a crucial role during times of crisis in African families. Kayongo-Male and Onyango (1991:63) rightly stated that:

The extended family has been a noble characteristic of African society especially at times of death, during disputes and in production and the upbringing of children. It was seen as a social security system.

However, of special concern to us also is the extended family's role of care and upbringing of children in times of death and sickness.

*Extended family in sickness and death:* In times of sickness the extended family members converge at the sick person's home to decide how to resolve the crisis. In Shona culture (i.e. Zimbabwe), to which the researcher belongs, this practice is denoted by the idiom *chara chimwe hachitswanyira inda* [lit. one needs two thumbnails in order to crush/kill lice]. This practice denotes that when a person is in crisis, especially of critical sickness or death, he/she needs others for support, comfort, strength and guidance since the person's orientation may be disturbed by the crisis. Such a practice ensures that members of an extended family are always present to provide emotional, spiritual, social and psychological support to the affected person and family.

*Orphan care:* In contemporary times, especially with the HIV/AIDS devastation that is killing young parents, orphan care is an enormous challenge. It is important, therefore, to consider the contribution or role of the extended family in this regard. Kayongo-Male and Onyango (1991:63) rightly asserted that at times of death the children of the deceased were looked after by the extended family, often the uncles or aunts. The children brought into the household of relatives were treated equally with those of that household. This means that the children were given an equal chance to grow and develop and look after others in adulthood.

It was considered anathema for one not to look after the orphans of the deceased. Kayongo-Male and Onyango (1991:64) are further right in saying that, in Africa, the majority of the rural population cannot look to the state (government) for help nor expect the state to help them as a right, but they expected help to come from their relatives. To cite a practical example, when the researcher's sister died in 1997 and left behind four orphans, they were divided among the close relatives to be cared for and looked after. Furthermore, apart from the extended family joining hands in raising

the orphans, the whole community was involved. As a child grows in the community every elder has a responsibility to discipline the child according to the norms and standards of the community, thereby helping the child to be integrated like any other child.

*The challenge and drawback of extended family:* Despite the advantages of the extended family, it has its own challenges, especially in the wake of Western individualism. Because people live in a close network, when certain members of the family rise through the social strata, hostility, petty jealousy, etc. develop. Aggression, therefore, is directed towards the member who is failing to meet the expected social functions. The extended family feels they are denied their right to be supported and to influence the concerned relatives' income. This practice can actually have very detrimental effects. For instance, at times of death, the surviving family members may look forward to a portion of the property of the deceased (Brown 2004). They share the family property, houses, etc. without considering the children. The women and children could be the target of such injustice.

Regarding pastoral healing, the extended family may play a very negative role. A sick person who wants to uphold the Christian mode of healing may find him/herself in serious conflict with the extended family and community that hold to traditional practices. The community might want him/her to conform to the traditional way of healing, e.g. sacrificing to ancestors, which conflicts with Christianity. The tension may lead to the sick person being cut off from the network of relationships because of societal/family deviance. This, therefore, aggravates pain and suffering. Hence, to avoid being cut off, one conforms. In this case the extended family becomes a stumbling block to pastoral/Christian therapy. This phenomenon is partly the cause of many African Christians' oscillation between traditional religious practices and Christianity in times of suffering.

In summary, the African extended family is central in African healing despite its drawbacks. Berinyuu (1989:7) rightly observed that more than 55% of Africans seek African therapy (extended family counselling) as opposed to pastoral counselling (only 12%) or a Western-trained counsellor (33%). Members of the family contribute materially, emotionally and spiritually to the needs of the affected family and person. They care for one another in sickness and death, which is crucial in HIV/AIDS home-based care. The orphans too can easily be absorbed and integrated into the extended family structure. It (the extended family) provides a crucial support buffer in the suffering of the poor and HIV/AIDS affected people in Africa. Thus a systems approach is not foreign to Africans. It is central to their existence as a community. Therefore in our quest for a practical

ecclesiology that addresses poverty and HIV/AIDS, we should harness this network of relationships and channel it to *koinonia* care (mutual care of believers).

However, at this point regarding my attempt to develop a practical and relevant ecclesiology within the HIV/AIDS pandemic, I therefore pose the following important question: how can the African church be informed by the notion of the extended family as well as of Scripture in order to design a relevant and appropriate ecclesiology that can address the poor and HIV/AIDS-affected people in the church and community?

In the above discussion the family unit or household has been identified as a caring unit. The Old Testament *bet 'ab* and the African extended family systems are the crucial vehicles of this caring system. The group identity discouraged people from acting selfishly and focusing on the self, the "I". The group family identity; communal care in crisis, sickness and death; community integration of orphans (orphan care); communal care for the poor and widows, all provide a way to how life could be lived amid the challenges of HIV/AIDS and poverty. Members are challenged to be involved with the affected people. The close network of the African extended family and community, much like communal Jewish life that sought a group identity, compelled members to seek the good of the others (group interest). No one would fold his hands when the poor are begging and going hungry. The sick were well cared for within the community. The members helped one another in times of crisis and mourning, thereby bringing valuable support in grief. Thus as a system there was interdependence and "being there" for one another. Each person sought the continuity of the group and the good of others in the group. What hurts one person hurts the whole group.

The previous discussion considered the family as a household unit and the spiritual family. However, within the conditions of poverty and HIV/AIDS in Africa, we should link the household unit to the spiritual family (church). By linking the family (household) unit and the church (spiritual family) we provide a horizon in which the church becomes the practical entity within the community. Vos (2003:231) discerned this link and commented, "the role and meaning of the family in African society provides a link with a spiritual family". Vos's argument is that the family unit should be a strong base for the church, which Moltmann (1993) rightly calls grassroots communities.

The above discussion thus highlighted the church as a family of believers that should care for one another, which should inform our ecclesiological design. This *koinonia* approach underlines the fact that a systems approach is important as a theoretical base. Therefore I pose the following questions:

what does the family system imply? What is the nature of the relationship of the members of the family system? How does a family system approach inform our ecclesiological design in the context of the poor and the HIV/AIDS pandemic?

#### *4.4. On being the Church: A Systems Approach*

A system is a collection of interrelated components and the existing relationships among the components. A systems perspective is the most inclusive means of examining the nature, function and health of families. It basically means whereby each part of a system is connected to, or can have its own effect upon, every other part. Each component, rather than having its own discrete identity or input, operates as part of a larger whole. The components do not function according to their nature, but according to their position in the network (Friedman 1985:15). Augsburger (1986:178) suggested that the best way to understand a systems perspective is to understand the connectedness of the following concepts: element, structure, process and system.

Elements are simply things, material things, conceptual ideas, logical propositions, etc. that are unconnected, which form a heap without structure. Structure is a pattern of elements – an ongoing configuration of elements related meaningfully to each other. However, what is missing in the concept of structure is the notion of process. Process is a pattern of events – an order of movement, change and growth in sequence and repeated occurrence, not randomly but with regularity. Combining process and structure produces a system. Thus Augsburger (1986:178) defines a system as a structure in process; that is, a pattern of elements undergoing multiple processes in cyclical patterns as a coherent system – a structure of elements related by various processes that are all interrelated and interdependent.

Graham (1992:39-40) and Friedman (1985:18) identify the following characteristics of a systems view of reality:

- ☞ It affirms that all elements of the universe are interconnected in an ongoing reciprocal relationship with one another;
- ☞ It affirms that reality is organised. The universe is an ongoing totality, of which the elements are interrelated;
- ☞ It emphasises homeostasis, or balance and self-maintenance. Balance is maintained by transactional processes such as communication, negotiation and boundary management;
- ☞ It emphasises creativity in context, of finite freedom. Although systems are self-maintaining, they are also self-transcending.

In addition, to help us understand family systems theory, Friedman (1985:19) identified the following important interrelated concepts that distinguish the

family model from the individual model: *the identified patient, the concept of homeostasis (balance), differentiation of self, extended family field, and emotional triangles*. Augsburger (1986:180-186) also identified the same concepts. However, since this research is concerned with the church family, these concepts will be considered and applied in that context, especially congregational involvement with the poor and HIV/AIDS affected people.

#### **4.4.1 The identified patient**

The concept of the identified patient in a family system refers to the family member with the obvious symptoms as the sick one, but the member is just the one in whom family stress or pathology surfaced (Friedman 1985:19). In a child it can surface as excessive school failure, obesity, etc.; in an aged member it could show up as senility, confusion, etc.; and in a congregation (church) family it could surface as burnout, drinking, etc. With respect to our research, it could be that the person who is diagnosed as being HIV positive leaves the church/congregation (a point which will be elaborated on later).

The purpose of using the phrase “identified patient” in family systems is to avoid isolating the problem family member from the overall relationship system of the family. The premise at the root of the family system, Friedman says, is that physicians do not assume that the part of the human organism that is in pain or failing to function properly is necessarily the cause of its own distress. The colour of a person’s skin can be related to a problem in the liver. Thus the problems in any organ can be related to excessive over-functioning, under-functioning, or dysfunctioning of another.

Systems theory therefore contends that, when a person is treated in isolation from his/her connections with others, as though the problem occurred solely its own, fundamental change is not likely. The assumption is that the problem can be recycled, in the same or different form, in the same or different member. Thus trying to cure a person in isolation from his/her family is as misguided and ultimately ineffective as transplanting a healthy organ into a body whose unbalanced chemistry will destroy the new one as it did the old.

If a family problem is unresolved and one member is isolated as problematic, it allows other family members to deny the very issues that contributed to making one of its members symptomatic. In our example of a person who is diagnosed HIV positive and leaves the church, congregation members can exonerate themselves and stigmatise the person to say he/she has left because he/she is immoral. Yet this does not address the apathy, rejection, discrimination and stigmatisation by the congregation members.

In fact the family projection process of this congregation family would be scapegoating, saying the person has HIV/AIDS and has now left to go where he/she belongs (immorality). Scapegoating, Friedman argues, suggests a far

more conscious awareness than is usually present when this process occurs in families. The creation of an identified patient is often as mindless as the body's rejection of one of its parts.

Another strand of family projection could be excessive care that is not sustainable. For instance, the moment the congregation member is diagnosed HIV positive the members start to over-assist the person, yet he/she still has many years still to live and is still capable. Pathology, Friedman argues, can also surface as a super-positive symptom of a striking over-achiever. Such congregational family members are likely to be overly stressed, since their position in the system allows little to function differently. In the human body severe over-functioning, as well as severe dysfunctioning, is itself evidence of a problem in a system and will, in turn, promote problems elsewhere.

The identified patient concept therefore means that, when a person who has been part of the church is diagnosed HIV positive or lost his job and leaves the church, he or she should not be viewed as having a problem. But this entails that one has to see other members of the congregational family (*koinonia*) to give them support or additional insight into why the identified patient has left. Thus with a family systems model it is possible to work with non-symptomatic members of the family. There are times where the symptomatic member is so unmotivated that it is probably advisable to work without him/her. For instance, a wealthy church could be located next to a poor informal settlement where HIV/AIDS is rife, but none of these poor or HIV/AIDS affected people belong to this church. Systems theory, especially the idea of identified patient, allows one to challenge such a church (i.e. it requires therapy).

In a nutshell, the identified patient in a family system implies that family therapy should not try to calm the family, but should treat crisis as an opportunity for bringing change to the entire system, with the result that everyone, and not just the identified patient, personally benefits and grows.

#### **4.4.2 Homeostasis (balance)**

Homeostasis is the tendency of any set of relationships to strive perpetually, in self-corrective ways, to preserve the organising principles of its existence (Friedman 1985:23). Individual models locate problem or illness on the character traits of individual members, while the family model conceptualises systems problems in terms of an imbalance that must have occurred in the network of its various relationships, no matter what the nature of the individual personalities. Family systems theory assumes that if a system exists and has a name, it should have achieved some kind of balance in order to permit the continuity necessary for maintaining its identity. It is not concerned with the question: do these types of personalities fit, but what has happened to the fit that was there?

Thus the concept of homeostasis (balance) explains the resistance a congregation (church) family may have to change. There could be endless meetings and persuasion of church members to embrace new church practices or activities. An example of such resistance is Dr Rev. Xapile's story in contained in the book *The church in HIV+ world* (2004:49), who began an HIV/AIDS-friendly church in Gugulethu (South Africa), where some church members felt they had to leave the church because the homeostasis was disturbed, and they were uncomfortable.

Friedman argues that, if a husband with a wife who lectures and threatens children to conformity seeks counselling, and the counselling destabilises the balance in the home (i.e. what she used to do though wrong), he would prefer to stop it even though the change may be right. In the same manner, some churches/congregations may prefer more fellowship breakfasts, where the church system is not disturbed rather than beginning poverty-relief initiatives in the neighbourhood in which resources are given out.

In maintaining the system balance (homeostasis) congregations would rather tolerate members who cause all sorts of problems, but they don't disturb or tamper with the status quo. They would rather be satisfied with downright incompetence, whereas creative thinkers who disturb the balances of things are ignored. For instance, members who try to stir the congregation to be involved in HIV/AIDS and poverty initiatives may be resisted strongly, while those who have nothing to contribute in church are preferred.

#### **4.4.3 Differentiation of self**

A family system seeks to keep itself balanced, i.e. it is self-corrective. It resists change and tries to maintain the status quo (homeostasis). However, differentiation is concerned with the resources available within a family system for helping it to overcome its homeostatic resistance. Thus in our case we can ask the question: how can few members in a church family that is apathetic and uninvolved in poverty and HIV/AIDS issues influence the congregation family position? How can these members act in a way contrary to the systemic balance? Systems differentiation provides us with a way of dealing with this. The human components of a family system have the capacity for some differentiation, i.e. the capacity for some awareness of their own position in the relationship system, the way it is affected by balancing forces, and the way changes in each individual's functioning can in turn influence that homeostasis (Friedman 1985).

Differentiation is the capacity of a family member to define his or her own life's goals and values apart from surrounding pressures to conform, to say "I" when others are demanding "you" and "we". It is the capacity to maintain a non-anxious presence in the midst of anxious systems, to take responsibility

for one's own destiny and emotional being. Thus differentiation is the capacity to be an "I" while remaining connected. For instance, as mentioned earlier, in a church family where members are not concerned about the poor and HIV/AIDS-affected people, there are some people who remain committed to the church, but get involved with HIV/AIDS ministry on their own. They get involved despite other members' indifference and resistance. Though these people are connected, but they act on individual (personal) convictions.

Bowen (cited by Friedman 1985:27) suggests that all members of the human family are placed on a continuum. Where one falls on the scale is determined in large part by where our parents and their parents were on the scale, with various children in each generation being slightly more or less mature than their parents. This parental influence in our case could be taken to refer to church or denominational tradition, which therefore means that denominations or congregation families that have a tradition of not being involved in social issues are highly unlikely to break (differentiate) from this tradition, i.e. do things differently. This type of family, Friedman states, is far less equipped to deal with crisis and they would quickly seek to redress the balance if the homeostasis is disturbed. This in a way explains why certain evangelical churches find it difficult to change their tradition. They don't know how to handle the changes (crisis), because they have been socialised to do things in a certain way.

It is the maintaining of self-differentiation while remaining a part of the family that optimises the opportunities for fundamental change. Thus the congregation family members who feel that they should be involved on issues that others are resisting - like HIV/AIDS ministry - should become involved (differentiate), while they remain attached to the congregation family. This may also apply at a denominational level, where certain local churches may feel they want to do things differently than the general denominational culture of apathy. These local churches should differentiate themselves, while they remain part of the large denomination (institution). In differentiation of self it should be noted that those family members who are least differentiated are the ones who usually sabotage the progress (change) that differentiated (creative members' initiatives) bring. For instance, some church members may strongly argue for more Bible studies, which does not disturb the church culture (homeostasis) than to start a congregation home-based care programme.

#### **4.4.4 Extended family field**

The extended family refers to the family of origin, our original nuclear family (parents and siblings) plus relatives (grandparents, aunts, uncles, cousins, etc.). The extended family does not have much application in this section, but what should be underlined is that understanding the processes still at work



regarding our family of origin, and modifying our responses to them, can aid in resolving immediate family problems. Specific patterns of behaviour, perceptions, thinking, theology (i.e. for the church), etc. can be influenced by parents (family of origin). But when family members see beyond the horizons of their own nuclear family and observe the transmission of such issues from generation to generation, they can obtain distance from their immediate problems and, as a result, become freer to make changes. This may also apply to the congregational family; a local church (under denominationalism i.e. institutionalism) might experience pressure from the denominational family (extended churches) to conform to certain practices, even though it wants to change. There could be resistance from the network of other congregations under one roof, if a church tries to implement a church HIV/AIDS ministry, e.g. the resistance that Dr Rev. Xapile encountered in the Presbyterian church in Gugulethu cited earlier. Thus the extended family can dilute or nourish natural strengths; it can be a weight that slows our progress.

Furthermore, the intensity of the extended family influence on a nuclear family can also be understood by tracing its multigenerational transmission. A church that has, over the years, inherited a culture of apathy towards the needy is less likely to differentiate from the tradition. The nuclear family therefore, though still connected to the extended family, should be differentiated. A congregation that belongs to a denomination that is apathetic towards the needy – for instance, the poor and those with HIV/AIDS – should make an effort to break (differentiate) from the extended family tradition.

#### **4.4.5 Emotional triangle**

Any three persons or issues can form an emotional triangle. Its basic law is that when two parts of a system become uncomfortable with one another, they will “triangle in” or focus upon a third person or issue, as a way of stabilising their own relationship with one another. A person may be said to be “triangled” if he or she gets caught in the middle as the focus of such an unresolved issue. For instance, husband and wife in conflict can triangle children. Conversely, when individuals try to change the relationship of two others (two people, or a person and his or her symptom of belief), they “triangle” themselves into that relationship (and often stabilise the very situation they are trying to change) (Friedman 1985). This may explain why zealous church members with initiative who are trying to mobilise other members – say, for HIV/AIDS ministry – end up losing their zeal and become cold.

The concept of the emotional triangle focuses on processes rather than content. It provides a new way to hear people, as well as criteria for determining what information is important. For instance, what Charles says about John tells you more about Charles than it does about John. What Charles

says to you about his relationship with John has to do with his relationship with you. Say, in a church/congregation family, one member (or elder) can go around telling people or pastor that another elder is influencing other people to start soup kitchens rather than Bible studies. Applying the triangle process analysis, the pastor or that other person should realise that the elder who is reporting is trying to get support for his lack of involvement and apathy towards social issues, and he thinks the pastor or that other person could share the same thoughts. Focusing on process in triangles illuminates and identifies problem members who gossip and negatively influence others in the church family.

With emotional triangles, the way to bring change to the relationship of two others is to try to maintain a well-defined relationship with each, and to avoid the responsibility for their relationship with another. For example, we can take the following triangle in a congregation: members willing to be involved in HIV/AIDS ministry, members unwilling to be involved in HIV/AIDS ministry, and the HIV/AIDS ministry issue. The members who are willing and motivated to do the ministry should proceed with the ministry, but still in close loving relationship with those who are unwilling. This means the willing members maintain their relationship with the other members, but are not pushing them into the ministry. Friedman argues that this approach may change the unwilling members to become involved than trying to force them.

In summary, a family system is composed of members who do not function independently of one another but as a unified whole. The parts are connected by a central sense of oneness. This oneness can be a healthy balancing of affectionate connectedness and respectful separateness; it can be an unhealthy “stuck togetherness” at one pole or an emotionally distant abandonment at the other extreme (Augsburger 1986:178). And the concepts of the family system: the identified patient, homeostasis, differentiation of self, extended family field, and emotional triangles highlight the relationship of individual members in a system. The relationship, however, provides opportunities and challenges to *koinonia* care to the poor and HIV/AIDS as discussed.

However, how can the teaching in scripture on the church family be connected to a systems approach? What does a family system imply for an ecclesiological design?

#### **4.4.6 Systems theory and the church: possible links**

Scripture teaches that God as the Father of the family provides, protects, comforts, has authority, etc. (Is. 66:13; Deut. 1:31). The concept of God as parent communicates God’s loving care and comfort, where the Father carries and stays by his child (Is. 63, Deut. 1). However, to be a child of God is to know this kind of support not only from the Father, but also from fellow believers as

well. Paul told the Galatians to “do good to all people, especially to those who belong to the family of believers” (Gal. 6:10). God sets the lonely in families (Ps. 68:6) not just in the care and comfort of human families, but in the fellowship of the people of God. God's family will be known by their love for one another (Jn. 13:35).

The numerous references to brothers and sisters in Scripture (as discussed earlier) is not decorative, but a call to Christian responsibility. The responsibility of the Christian family (church) goes beyond this: ministry to God - worship; ministry to believers - nurture; and evangelism (Grudem 1994:868). It goes further to mercy, as Grudem rightly adds. While the church is obligated to sing psalms and hymns (worship), nurture those who are already believers to build them to maturity, and evangelise (sharing the gospel), yet accompanying evangelism is also a ministry of mercy that includes caring for the poor and needy in the name of the Lord. But how are Christians steered to their duty through systems thinking?

Hill (1988:199) challenges Christians under what he calls “church as communion and brotherhood (sisterhood included)”. He reasons that the concept of communion or fellowship (*koinonia*) in the New Testament is crucial to the progress of ecumenical understanding among Christians. The basic meaning of the word is sharing or having in common. As an aspect of the church, it signifies a community of people who share with one another (i.e. within the system). They share a common faith, hope and charity. This amounts to their sharing a common life. Hill further argues that the metaphors of branches, parts of the body, etc. make it clear that the partnership of Christians is not a mere pooling of their own individual resources, for neither tree nor body is constituted by an association of separately living parts; the life that is shared exists only as shared, and in the application of the metaphors it is made clear that the life of the church is that of intense connectedness.

Brotherhood and sisterhood may be seen as both the context and the consequence of community; it is as a brotherhood and a sisterhood that Christians share these things, and it is sharing them that make them brothers and sisters. All members should participate in the life of the church. The church as communion and brotherhood and sisterhood does not negate structured hierarchy and order, but contradicts clerical authoritarianism. The fellowship of believers encourages mutual affection and care for one another: “love one another” (Jn. 15:12). And as believers care for one another they will “bear one another’s burdens, and so fulfil the law of Christ” (Gal 6:2).

Furthermore, an emphasis on the fellowship of believers with one another helps to overcome the excessive focus on the ordained clergy as the primary carers of the church (Grudem 1994:958). The fellowship and ministry to one another takes the form of words of encouragement or exhortation or wise

counsel (Col. 3:16). At other times it involves giving to assist the material needs of a brother or sister (James 2:16).

The metaphors of family, branches, parts of the body, etc. used for the church helps us to appreciate more the richness of privilege that God has for us by incorporating us into the church family (system - *koinonia*). The fact that the church is like a family (system) should increase our love and fellowship for one another. The metaphor of church as a body of Christ should increase our interdependence with one another and our appreciation of the diversity of gifts within the body (i.e. systemic function).

The church therefore as a connected system of Christians means that every Christian is attached to a unit. If one part is dysfunctional, the whole system is affected. If in a fellowship of believers there are burdened people, the whole church shares the burden and carry it together. And if there are poor and HIV/AIDS-affected people, the church should be empathetic and seek to comfort and provide for them. Thus for the church to function effectively, the needy people among them should be assisted, otherwise the system collapses. The family of God (brothers and sisters) is hurt when they see others in pain. They identify with them. The ideal family systems approach that the church should strive for compels Christians to shift from individualism to community (i.e. system), which encourages a bottom-up approach and not clericalism. Moltmann (1993:331) clarifies that “the concept of community is a term for a process, in the course of which a community determines its needs and goals, orders them, or brings them into sequence of priorities; develops the confidence and the will to do something about them”. In such a situation (bottom-up and mutual concern) each individual plays a crucial caring role. Thus every part of the body performs its function as part of a whole (system).

Thus far it has been underlined that Christians should care for one another because they are part of one family (i.e. system). The joys, sorrows, hurt, etc. should be shared. However, we should pose the following pertinent question: if the church (Christians) is compelled to care for and assist its members because they belong to one family (system), is there an obligation or responsibility for Christians (congregations/denominations) to care for the community or society (i.e. those outside the church)?

Although the emphasis of the New Testament on material assistance focuses on those who are part of the church (Acts 11:29, 2 Cor. 8:4, 1 Jn. 3:17), there is still an affirmation that it is right to help people, even if they do not respond with gratitude or acceptance of the gospel message. Jesus said, “Love your enemies, and do good, and lend, expecting nothing in return; and your reward will be great, and you will be sons of the most high; for he is kind to the ungrateful and selfish. Be merciful, even as your Father is merciful” (Luke 6:35-36).

Grudem (1994:868) comments that the point of Jesus' explanation is that we are to imitate God in being kind to those who are ungrateful and selfish as well. Moreover, we have the example of Jesus, who did not attempt to heal only those who accepted him as Messiah. Rather, when great crowds came to him, he laid his hands on every one of them and healed them (Luke 4:40). This should give encouragement to carry our deeds of kindness, and to pray for healing and other needs, in the lives of unbelievers as well as believers. Grudem further says such ministries of mercy to the world may also include participation in civic activities or attempting to influence governmental policies to make them more consistent with biblical moral principles. In areas where there is systematic injustice manifested in the treatment of the poor and/or ethnic or religious minorities, the church should also pray and – as it has the opportunity – speak against such injustice. All of these, Grudem says, are ways in which the church can supplement its evangelistic ministry to the world and indeed adorn the gospel that it professes.

In addition to Grudem's argument, it is also important for Christians to understand the nature of Christian care and love (*agape*). The love should be sacrificial and [out-given] (unconditional). It should not expect anything in return. Christians are compelled to assist wherever possible, regardless of the person's religious affiliation. Our mandate is to love and give unconditionally. And by the church extending its love to those outside, it embodies Christ who is the ultimate carer for all humanity.

Thus far I can sum that systems theory views each component as part of a whole. Each part or component, rather than having its own discrete identity or input, operates as part of a larger whole. All parts are interrelated and interdependent. We argued that systems theory could be applied to the church family. Systems theory that views each believer as being part of a whole (church) with interrelationship and interdependence to others poses a *diakonic* challenge. The church (faith community - *koinonia*) is challenged to care for its members (mutual care). Believers identify with one another and share their burdens. And the caring extends further to those who are outside the church. Therefore for the church to be able to respond to the HIV/AIDS pandemic, it should adopt a systemic ecclesiological approach driven by the family metaphor, which promotes home (family) caring (as argued earlier).

But how could I proceed from a theoretical systemic ecclesiological approach of church family to steer church members to action practically? How can the attitude of people be shifted from apathy to empathy, which encourages action?

The challenge to poverty and HIV/AIDS is the persistent apathy and indifference that many people have towards the affected people. HIV/AIDS-affected people are in many cases stigmatised and discriminated against. And

sadly, some churches also join in this ungodly practice. Such an attitude should be challenged. Members' perceptions and attitudes should be challenged to change. A systems approach, however, encourages people to accept and embrace one another irrespective of the situation. The affected people are not viewed as "them" but "us". They are part of the system. If the church adopts this attitude, it would identify with the many poor and HIV/AIDS-affected people, which in Ackerman's words "we are [will be] people with AIDS i.e. the church has AIDS". Thus a systems approach challenges people's apathetic attitude to empathy, and promotes involvement and action. But what are the dynamics of this attitude change?

#### 4.5 *Attitude within a Hermeneutics of Care: Towards an Ecclesiological Understanding of HIV/AIDS and Poor People*

My quest for a responsive ecclesiological approach to the poor and HIV/AIDS-affected people, which we have argued should be driven by the church family metaphor, should serve to focus people's attitudes, otherwise the project may just end at a theoretical level. Church and community members may continue in their old paths if not presented with a practical challenge and method to assess their position. Thus it is right, as Browning (1983:3) noted, that there is a growing hunger to make theology in general more relevant to the guidance of action and to bridge the gap between theory and practice, thought and life. In addition, Bass (2002:1) introducing the book *Practicing Theology: Beliefs and Practices in Christian Life*, aptly poses the question: "But what does that have to do with real life?" This question to theoretical formulations and dogma should haunt the church, especially in Africa. But how can this be made possible? How could Christians be challenged to action?

The point I have underlined is that through church family system thinking, the mutual care of believers is encouraged. Care should shift away from a unilateral professional approach or clericalism to the mutual care of believers (*koinonia*) or a bottom-up approach. Thus Obeng (2000:7), like Louw (1998:16), rightly emphasises that a pastoral carer or counsellor does not necessarily have to be a pastor or a church minister. Any person within the church can fulfil that role. In fact it is a congregational (*koinonia*) function. Crabb (1979) also underscores the same thought that pastoral care is the responsibility of all believers. Thus every Christian is a pastoral caregiver.

The poor and HIV/AIDS-affected people who come to church and those we encounter in the community should experience care and love through us as conduits of God's healing grace. Through compassion and identification with these people who are suffering (because of poverty and HIV/AIDS) and thinking of them as part of us (i.e. systems thinking), we bring healing. Designating

compassion and identification metaphorically, church members should embody the metaphors (i.e. shepherd, suffering servant, wisdom and *paraklesis*<sup>8</sup>) that promote healing (see discussion on metaphors in Chapter 5). Among these metaphors, care in suffering (as in the case of HIV/AIDS) resides in the way that it understands and communicates the meaning of the *paraklese* metaphor. It understands the encounter between God and humans from the perspective of the comforting effect of God's grace, presence and identification with human need and suffering. It interprets this comfort in such a way that God's care reveals a horizon of meaning, which in turn gives hope and generates faith (Louw 1998:98-99).

However, while I argue for a practical ecclesiology driven by the family metaphor with underlying systems principles, we should be aware that change in people's attitude to embodying these healing metaphors is not automatic. It requires the Holy Spirit to change people's attitudes. The Spirit illuminates the truth (hermeneutics), changes and renews the believers' view and perspective to people's suffering - existential issues (agogics), and actualises ecclesiastical services (*diakonia*). Therefore we assume that under pneumatological influence and compulsion, Christians' apathy could be combated. Christian caring becomes visible to people.

But how can we focus the church family - *koinonia* (i.e. system) - caring function on our discussion of poverty and HIV/AIDS? The discussion on the interplay between poverty and HIV/AIDS (Chapter 3) revealed that some people have resigned from living. Life has become meaningless. And attempting to correct their risk behaviours is normally resisted, because death or life to them is the same. They argue that they may die today or tomorrow from hunger, hence they don't fear an HIV/AIDS death. In the story by an orphan, Kevina, and grandmother Lucy, whose children died of HIV/AIDS, cited from Cohen earlier (Chapter 3), sentiments of despair and hopelessness are expressed. Hunter (2001:123) in *Reshaping Societies HIV/AIDS and Social Change* has further testimonies of poor people: "Poverty is pain. It feels like a disease. It attacks a person not only materially, but also morally. It eats one's dignity and drives one into despair. Poverty is like living in jail, under bondage, waiting to be free" (2001:123). These testimonies underscore the existential issues identified by Louw (1998:3) in pastoral care: anxiety (voidness, misery and threat to livelihood due to poverty), guilt (feelings of disappointment, shame and failure due to poverty circumstances), and despair (helplessness, hopelessness and meaninglessness of life as a result of poverty). Therefore could pastoral care (ecclesial care) address the situation? What is these people's perception of God? How can the Christians' attitude be shifted from apathy to empathy, leading to involvement in people's lives?

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<sup>8</sup> See Louw (1998) for detailed discussion of pastoral care metaphors.

Louw (2003:209-218), in the article “The Healing Dynamics of Space. Relational and Systemic Therapy in Pastoral Care to People Suffering from Poverty”, attempts to answer similar questions to those posed above. He stated that at stake is the question: how is it possible for pastoral ministry to give back to people their human dignity in order to help them not just to survive, but to live a fully human life despite severe poverty? The challenge to pastoral ministry is *inter alia* to help people survive and to discover dignity and identity (2003:209). The article focuses on attitudes and the pastoral art of understanding, the healing dynamics of relationships and the link between pastoral hermeneutics and the social problem of poverty. Human dignity has much to do with value and the quality of human networks and social relationships. Thus, while one should admit the immense complexity of the issues of poverty and HIV/AIDS in Africa (Chapter 3) and that there are probably no easy answers or remedies or cures, pastoral ministry – apart from developing effective outreach projects – has the task to help people to live a meaningful life and to discover human dignity despite poor conditions.

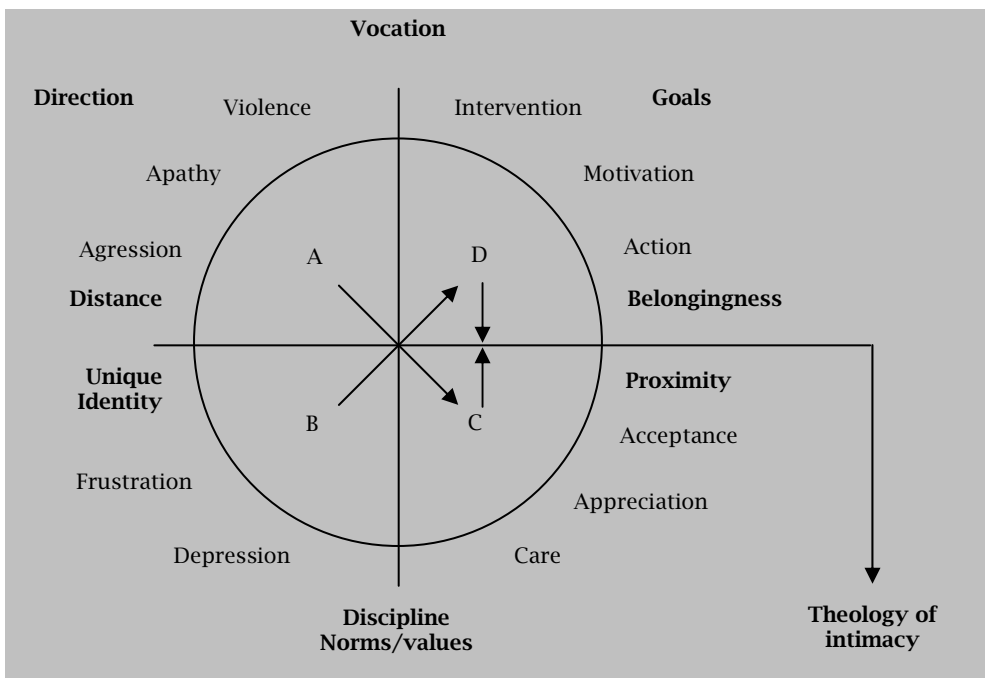
The way people respond to other people's situation and their own situation is largely determined by their conceptualisation of God. Our God-images can make us aloof and insensitive and create distance from the poor, if we perceive our God as a powerful one who grabs resources from others and piles them on us. In that case, the God of the poor would be weak and hence responsible and blamed for their poverty. On the other hand, the poor people may perceive God as one who is apathetic and unhelpful. Therefore Louw states that a pastoral hermeneutics applied to poverty should reveal the intentionality behind the perceptions of society toward poverty. Any perceptions and interpretations of God as distant and apathetic should be dispelled. The God-images of God as a Friend, Partner and Companion that views God as being-there, being-with and being-for should create healing within which people can be empowered to use hope in a creative and imaginative way, despite the situation of poverty and HIV/AIDS.

Pastoral healing is about salvation. The term *cura animarum* means cure of souls. And the soul is the qualitative principle of life (*nefesh*) as displayed within a very specific disposition or condition before God. Healing theologically thus refers to the event of being transformed from a condition of death into a condition of life. This new condition is an indication of a new state of being: being accepted unconditionally by grace and being restored into a new relationship with God; i.e. a relationship of peace, reconciliation and forgiveness. Soul healing in pastoral care refers to pastoral acts and intentions that emanate from salvation. It opens up new avenues of understanding about what our human vocation is. It also refers to a sense of direction, which instils meaning and reflects the contextual implication of the gospel for life issues. Healing therefore is that which enables us to be fully human in relation to our



society, our environment and ourselves. In such a state, therefore, Louw argues, a person who has HIV/AIDS and is poor can be more healthy than someone who is HIV/AIDS free and wealthy. But isn't Louw's pastoral therapy an abstraction? How can Christians shift from apathy to empathy regarding their view and involvement with the poor and HIV/AIDS-affected people?

Louw concretises a pastoral therapy model for the poor, which he calls the hermeneutical model of space therapy represented diagrammatically below. This model, apart from being a practical therapy analytical model, is useful to determine the level of ecclesial (*koinonia*) involvement (i.e. *diakonia*) with the poor and HIV/AIDS-affected people to guide ecclesiological practices. For instance, in African contexts where many people are affected by HIV/AIDS, if a minister or a congregation is not involved with the affected in the community, it means the level of the attitude is at A or B in the model. Furthermore, the model could be used in mapping congregational involvement, where members could be located/placed in different quadrants and challenged/encouraged to be involved.



The philosophy behind this hermeneutical model for space therapy is that people's experience of worth within relationships is determined by the affective polarities of distance and proximity (the human quest for intimacy), as well by the normative polarities of vocation and discipline. These polarities demarcate a space wherein different positions are possible: A = apathy; B =

frustration; C = appreciation (care/acceptance); D = motivation (intentional actions). These four positions display different attitudes and determine the quality of communication within the human encounter. The quality of the overall dynamics is determined by a theology of grace and intimacy, i.e. to be accepted unconditionally without fear of isolation and the anxiety of being rejected.

The value of this hermeneutical model to, for example, the *problem of poverty in pastoral ministry* (my emphasis) is that it helps people to understand the dynamics of space. Within pastoral ministry space means the creation of an understanding which challenges people to change their attitude. When one understands one's position within the undergirding dynamics of space, it helps one to shift position, for example, from A (apathy) to C (acceptance); from B (frustration) to D (motivation/action). The movement for change is always into the opposite direction and quadrant; A is the shadow of D, and B is the shadow of C. Both C and D should be viewed as supplementary to one another (Louw 2003: 214-215).

This model therefore means:

- ≈ The social problem of poverty cannot be addressed meaningfully if people and society approach suffering people from a position and attitude of apathy and frustration. These positions also inflict apathy or frustration on poor people. Positions of motivation and appreciation create a sense of dignity, which inspire people to respond in a more responsible way. At the same time people are encouraged to set new goals in life. They are challenged to start with appropriate actions, which lead to new creative opportunities of living (2003:215).

The model helps pastoral (ecclesial) care givers (*koinonia*) to understand the being functions of the poor and HIV/AIDS-affected people, thereby leading to proper interventions. As highlighted earlier (Chapter 3), poverty in poor communities is cyclical. Poverty is a cultural cycle that needs to be broken. Louw is right that poverty has through many generations “becomes a stance in life” (2003:215). It generates despair and hopelessness. The inherent value, therefore, of Louw's model of space therapy is that it helps the caregiver (or *koinonia*) to understand his position in the quadrant and also the position of the poor and HIV/AIDS-affected person, which would lead to a shift within the quadrant. The caregiver would become involved in the issues of the affected (poor and HIV/AIDS) people, while the affected people also change their perception and view of life. Thus it unearths and challenges pastoral carers' (faith community - *koinonia*) apathy and encourages empathy and sensitivity to the needy, which is concretising God's love and care.

## 4.6 Summary and Conclusion

This chapter argued that the faith community/church, to be an effective conduit of God's love and compassion to the poor and HIV/AIDS-affected people, should embody the rich biblical metaphor of family that encourages ecclesial (*koinonia*) care. This metaphorical designation would challenge Christians' fellowship (*koinonia*) to change their attitude from apathy to care for one another.

Several points therefore emerge from the discussion.

- ≈ Church (*ekklesia* - lit. "called out") refers to the community of believers who profess faith in Jesus Christ. The word may refer to a small group of believers in a house, a region, or universally. These people who are called out by God have similar functions worldwide. One such function is responsibility to care for one another, especially in the context of poverty and the HIV/AIDS pandemic.
- ≈ Practical theology, as a special discipline that deals with practical and social issues, is concerned with theory/reflection and praxis/action. It is the empirically oriented theological theory of the mediation of the Christian faith in the praxis of society. It has three main components that demarcate it: the community of faith and its belief; interpretation and communication; modification and transformation. Thus practical theology is *fides quaerens intellectum* (faith seeking ways of understanding); *fides quaerens verbum* (faith seeking ways of conversing and communication); and *fides quaerens actum* (faith seeking ways of appropriate action and doing), under the Holy Spirit's influence. However, to avoid the pitfall of making social action the end, a hermeneutical model of practical theology should be adopted. A hermeneutical model implies an ecclesiological approach, which dovetails with our argument for a church family system. It focuses on ministry - the development of spirituality and the transformation of people and the world. This means that whatever acts of mercy that people do are not an end in themselves, but meant to help people to become reconciled to God, who is the ultimate solution to the plight of humanity's problems of poverty and HIV/AIDS.
- ≈ In attempting to come up with a practical ecclesiological approach, the church should be perceived in terms of a systems approach through metaphors that encourage members to assist one another. Thus the nature of the church systems function can be depicted by metaphors like family, body of Christ, etc. These metaphors all emphasise Christians' connectedness and responsibility, but the family system is the most relevant and applicable for the poor and HIV/AIDS-affected people in Africa.

The family stories make up a big part of the Genesis narrative – Adam and Eve, Noah, Abraham, Isaac and Jacob. It is the main social context within which people live their daily lives. The family is also the unit through which God's covenant has been perpetuated. The ideal redeemed human family has been identified as one that is ordered and in which people care for one another. However, this research is concerned with the spiritual family (church). The spiritual family (church) refers to the people redeemed by Jesus who profess faith in him. These people become spiritual brothers and sisters who are in communion bound by God's love. The communion of believers (congregational system) entails acceptance and identification with each other, which leads to sharing experiences of their joys, sorrows, pains, etc., which is crucial for HIV/AIDS healing.

Furthermore through the fellowship (*koinonia*) of believers, it compels members to identify with one another in all circumstances; individualism is dispelled and communalism encouraged. This emphasis on mutual care means that clericalism (a top-down approach) is discouraged and a corporate paradigm (bottom-up approach) of believers is encouraged, which Moltmann calls “grassroots” communities. Thus believers interact with one another in fellowship (mutual care) and needs are identified and responded to appropriately. Apart from the Christian family only caring for one another, it should look outside to the community. The nature of the Christian calling is that of unconditional care and love to the world. Thus the focus of Christians (church) should go beyond the congregation or denomination to society (community-directed paradigm).

- ☛ In the Bible, especially the Old Testament (Jewish caring system), the *bet 'ab*, which is equivalent to the African extended family, was central in providing primary care for the sick and needy members. But within the broad Jewish system, *Yahweh* instituted various laws that governed the day-to-day living of Israelite people. There were laws for care of orphans (fatherless), widows, the sick and aged, care for the poor, etc. However, Israel failed dismally in caring. The prophets spoke against the leaders of the nation that exploited the poor and needy, whom they were supposed to protect.

In the New Testament period (Greco-Roman world), though they held to the Jewish family structure, a new concept of family arose. The word family was used metaphorically. The new family is the community of believers, i.e. God's household or family. Therefore in formulating a theology of family for HIV/AIDS care, we should underline that family should be perceived as the church, i.e. family of God (spiritual family). Though family is rendered as *bet 'ab* extended family (Old Testament), in the New Testament the inclusion of all people in the church (the family of God) takes precedence.

We should speak of a bigger family – the family of God, the church. And importantly, the church family like the *bet 'ab*, presents a challenge to members to think in systemic terms. They should not view themselves as “I” but “us”. Hence, church family (i.e. metaphor) is the appropriate and relevant rendering of family that we suggest.

- ≈ The African extended family system is the important structure that has/is providing a care support function in Africa. The system may provide healing in times of crisis; it assists with practical care (e.g. food handouts and ministry of presence) in sickness and death; it provides structure for orphan care, adoptions and integration when parents die; and numerous other care and support functions. However, important though the extended family may seem, there is tendency for hostility and petty jealousy when others succeed, which is a drawback. Furthermore, it may impact negatively on pastoral healing when the relations network is in opposition to Christianity. It exerts pressure on one to conform to unbiblical practices, and refusal may entail being cut from the network, which aggravates suffering and pain.
- ≈ The common feature of the African extended family and biblical family system identified is servanthood, which should be incorporated by the church, since there is great deal of teaching on *diakonia* in scripture. Both systems to some extent exhibit this Christian ethic of service. Within the family system one does not view oneself in isolation, but as part of a community/family system in which you don't only seek your interests but the interest of others. Life is not about “me – I”, but about “us”. The epitome of selfless giving and sacrifice is the Lord Jesus Christ, who laid down his Lordship and gave up his life as ransom for sinners. This example of unconditional selfless and sacrificial love should be the engine and motivation for ecclesiological practices.
- ≈ The indicators for successful poor and HIV/AIDS ecclesial care in Africa are the communal structures that are already in place through the notion of *ubuntu*. This traditional African concept embraces the notion of compassion and care based on the common humanity of the people (Laurence 2001:34). Though this structural system may require moderation, there are lessons that the church should learn in order to provide effective and successful care in Africa. Church members should not view themselves in isolation, but as part of a system which challenges them to address the interests of others, especially those with HIV/AIDS and the poor. This systemic approach therefore should be at the heart of the practical ecclesiological design.
- ≈ The Church family (metaphor) (i.e. *koinonia*) with underlying systems principles implies that Christians should get involved with people in need, such as the poor and HIV/AIDS-affected people. Getting involved with needy people, however, entails an attitude change. Christians (church

members) should shift from apathy and indifference to the suffering people towards empathy and identification, which encourages involvement (action). Thus when Christians embody the family metaphor, it would lead to belongingness and an acceptance of (identification with) the poor and HIV/AIDS affected people. In so doing, they perform a *parakletic* function for the poor, which instils hope.

This chapter thus underlined the fact that a relevant practical ecclesiology that addresses poverty and HIV/AIDS is one that functions according to systems principles. And for this approach, the metaphor or image of church as family (i.e. system) has been proposed. There are lessons from Scripture and the African extended family on systems functioning that could be applied for effective HIV/AIDS care. Christians should accept (identify with) and serve one another. Identifying with the poor and HIV/AIDS-affected people brings hope and healing. And this is possible through church (*kononia*) care that embodies the family metaphor, where members seek the group interest not individual interests.

However, if we have identified a practical ecclesiological (*koinonia*) approach that is driven by the family metaphor (with underlying systems principles), how can this approach be utilised in pastoral care to instil hope and meaning to HIV/AIDS-affected people? This question introduces us to the next chapter: pastoral care for and counselling to HIV/AIDS affected people.

# V.

## *Pastoral Counselling to HIV/AIDS affected<sup>1</sup> People within an African Setting*

### 5.1 Introduction

The previous chapters outlined the HIV/AIDS information and related issues in Africa (Chapter 2), delineated the interplay between HIV/AIDS and poverty in Africa (Chapter 3), and underlined the church family system (*koinonia*) as a practical ecclesiological approach that addresses the poverty and HIV/AIDS situation in Africa (Chapter 4). Through systems principles, Christians are challenged to identify and provide care and support for affected people.

Uys (2003:7) in *Home-based HIV/AIDS Care* identified counselling as the main care and support that can be provided to HIV/AIDS-affected people. And the challenge to Africa is equipping ecclesial members to offer effective counselling in order to cope with the pandemic, especially in the context of poverty. Van Dyk (2001:200) rightly observed that:

*The sad reality in Sub-Sahara Africa is that very few HIV- infected people indeed have access to trained counsellors outside the pre-and post-test counselling context. This makes it vitally urgent to equip*

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<sup>1</sup> HIV/AIDS affected people as explained in chapter 1 refers to the HIV-infected person and the family caregivers (significant others).

*everyone in the helping professions with the necessary skills to be effective HIV/AIDS counsellors (2001:200).*

This, therefore, presents an enormous challenge to the African church (pastoral caregivers), since it is the main or most common institution present in many poor African contexts.

This chapter outlines pastoral counselling intervention to HIV/AIDS affected people, with special reference to the African scenario. It does so by surveying general counselling practices and focusing on the African counselling approach through: arguing for pastoral counselling as the approach that can meaningfully deal with HIV/AIDS healing in Africa; highlighting a healthy interdisciplinary relationship between psychology and counselling, with a focus on Africa; and importantly, it discusses the centrality of the African worldview and culture in pastoral assessment and therapy. The chapter wants to assess the impact of such a worldview on counselling within an African setting.

The chapter, therefore, argues that pastoral counselling in Africa should be much more communal and group oriented than merely focusing on the needs of the individual in order to address the issue of HIV/AIDS in a poor environment. This approach is appropriate to deal satisfactorily and meaningfully with the plight of HIV/AIDS-affected people, thereby offering them support (through *kononia*) and strong hope after the disclosure of their HIV-positive status (i.e. life beyond infection). Hope instils a positive attitude to life, which is instrumental for physical healing, immunity building and psychological and spiritual coping.

## 5.2 *Pastoral Counselling: An Interdisciplinary Approach*

### 5.2.1 **A brief history of pastoral counselling**

Pastoral care and counselling, known as *cura animarum* (cure of souls), is an expression of an age-old activity (Lartey 1997:19). Lartey traces the activity of the “cure of souls” back to 2800 BC. He proves that in Egypt and Babylon sages were the curers of souls; 1 Kings 4:31 also refers to sages who are compared to Solomon’s wisdom. Socrates also wanted to be called a healer of souls. Much can be said on the historical developments, but the Christian era is of primary interest here.

In *Pastoral Care in Historical Perspective*, Clebsch and Jaekle (1964) stated that Christian pastoral care drew from a specific human, historical, cultural and ecclesial context. They identified four basic functions of Christian pastoral care: healing, guiding, sustaining and reconciling. Each of these functions is dominant at a specific time in church history, depending on circumstances. For instance, during persecutions (180-306 AD) “reconciling” Christians to the



church was important, as they were undergoing pressure to renounce their faith. During Constantine's era (post-313 AD), when Christianity became a part of life, "guidance" was important as people sought guidance on how to conduct their affairs.

Apart from the four functions that Clebsch and Jaekle (1964) identified (i.e. healing, sustaining, guiding and reconciling), Clinebell (1984:43) added nurturing. Lartey (1997:37-42) added two more, i.e. liberating and empowering. In history, each of these functions is evident in how they were practised and in contemporary caring and counselling.

### **Summary of the functions**

<b>Pastoral care function</b>	<b>Historical expression</b>	<b>Contemporary caring and counselling expressions</b>
Healing	Anointing, exorcism, saints and relics, characteristic healers	Pastoral psychotherapy, spiritual healing, marriage counselling and therapy
Sustaining	Preserving, consoling, consolidating	Supportive caring and counselling, crisis counselling, bereavement caring and counselling
Guiding	Advice-giving, devil-craft, listening	Educative counselling, short-term decision-making, confrontational counselling, spiritual direction.
Reconciling	Confession, forgiveness, disciplining	Marriage counselling, existential counselling (reconciliation with God).
Nurturing	Training new members in the Christian life, religious education	Educative counselling, growth groups, marriage and family enrichment, growth-enabling care through developmental crises.
Liberating	-	Raising awareness about sources and causes of oppression and domination in society.
Empowering	-	Encouraging one to develop one's own/alternative base.

Lartey (1997:73-78), writing with an African inflection, explored ways in which the term pastoral counselling has been used. He identified six ways:

- ≈ Secular usage, where one is concerned about the welfare and well-being of persons with whom one is in a relation, or for whom one is responsible;
- ≈ Counselling by the ordained – referring to counselling by those in ministry;
- ≈ Counselling with a religious frame of reference, which refers to counselling that takes religious problems seriously, and that is informed by the counsellors' concern for ultimate values and meanings (religion in its wide sense);
- ≈ Counselling offered within and by a community of faith;
- ≈ Christian counselling, which seeks to integrate the Bible with psychology;

- ☞ Counselling for the whole person, which seeks to do counselling holistically.

Lartey's observation is useful to show how different people may view pastoral counselling. Nonetheless, to have a well constructed and a working definition, Clinebell's (1984:25-27) and Louw's (1998:260) definitions are recommended (further discussion later). To his definition, however, Louw (1998:260-261) added:

*The term pastoral counselling refers to the fact that this structured being - with a parishioner is exercised within the communio sanctorum and has as its main goals: the development of faith, the enhancement of a Christian spirituality and the empowerment of parishioners' faith by communicating the fulfilled promises of the Gospel. Pastoral refers to the presence of God and the paracletic functions of the Spirit.*

Louw's definition coupled with Lartey's outline is illuminating. It underlines three valuable and critical issues in pastoral counselling, i.e. context, goal and method. The context is the community of faith, *communio sanctorum*; the goal is threefold, i.e. development of faith, enhancement of Christian spirituality, and empowerment of faith; and the method is the communication of the promises of the Gospel. During the pastoral counselling encounter, the Holy Spirit *parakletos* applies the healing. Louw outlines the whole focus of the pastoral counselling enterprise concisely. Therefore it is advisable for pastoral counselling to structure its activities in line with his assertion. Apart from providing a pastoral counselling focus, it sets a general, distinctive framework for Christian counselling in contrast to psychology.

In summary, the history of pastoral care and counselling (*cura animarum*), as discussed, is an age-old activity. Its functions over the years that have contemporary expressions are healing, sustaining, guiding, reconciling, nurturing, liberating and empowering. The term pastoral counselling, as Lartey observed, has both secular and Christian references, with the latter being the common usage. Crucial for us, however, in HIV/AIDS counselling in which we advocate for the faith community (*koinonia*) mutual care, is that it clearly spells out the context, goal and method of pastoral counselling. The context is the community of faith (*koinonia*); its goal is development of faith and spirituality; and the method is communication of gospel promises that are applied by the Holy Spirit. This implies that in HIV/AIDS crisis a counsellor should aim at inculcating faith and spiritual development, which arguably sustains the person.

In recent years, however, pastoral counselling has been influenced by psychology (Miller and Jackson 1985), something which is increasing in Africa.

So how can pastors maintain a healthy relationship between psychology and Christianity or the Bible?

### **5.2.2 The role of psychology in pastoral counselling: towards an integrative approach**

The question of a healthy relationship between psychology and the Bible is important in pastoral counselling – especially in HIV/AIDS counselling, where psychological counselling seems to dominate. The dominance of a psychological approach may be discerned through the preference of many NGOs and other agencies that deal with HIV/AIDS issues for people with a background in psychological. It seems that some of the comprehensive books on HIV/AIDS care and counselling, like van Dyk's (2001) *HIV/AIDS Care and Counselling: A Multidisciplinary Approach*, are dominated by psychological thinking, despite attempting to integrate faith (not necessarily Christian faith!). The psychological dominance is further made clear by the ground-breaking book edited by Uys and Cameron on HIV/AIDS home-based care in South Africa entitled *Home-based HIV/AIDS Care* (2003) in which the ten contributors approach care and counselling from a psychological perspective. This is so, however, despite the fact that pastoral counselling is arguably the appropriate approach that may meaningfully address HIV/AIDS-affected people's crisis (discussion later).

However, for Africans for whom counselling is a community and extended family issue, we may ask: why is the question of psychology and Christianity or the Bible in pastoral counselling relevant? It is important for pastoral caregivers in Africa to note that, though psychological counselling was foreign to Africa, it is quickly making inroads into Africans' lives. Berinyuu's (1989:7) research in Nigeria revealed that in times of crisis in Africa 55% seek African therapy (community and extended family counselling), 33% seek Western-trained counsellors and only 12% seek pastoral counselling. Besides, the general trend towards psychological dominance globally does not and cannot exclude Africa as part of the global village. Therefore, an African pastoral counsellor should know how to relate to psychological knowledge, apart from knowing his African worldview. Hence, to fully grasp the meaning of pastoral counselling and appreciate its premise, it is useful to consider it in juxtaposition with psychology. A pastoral counsellor in Africa, therefore, should be able to integrate psychological information with the Bible and appropriately incorporate it within African counselling.

But what is the premise of psychological counselling?

Shilling (1984:12) notes about counselling psychology that there is no unanimity on the subject. In addition, Feltham (1999:1) referring to

psychotherapy and counselling in *Controversies in psychotherapy and counselling*, states:

*Indeed there is very little about which consensus exists. In an emerging profession that is characterised by over 400 different schools of thought and practice, practitioners agree on almost nothing – except perhaps the general worthiness and effectiveness of therapy, the sacrosanct nature of confidentiality and the taboo against sexual contact with clients.*

In this scenario, what one person believes passionately, another considers to be nonsense. But for a working description of counselling psychology, let us adopt what the University of Stellenbosch's Department of Psychology ([www.sun.ac.za/psychology/engels-web/couns-gen-info-htm](http://www.sun.ac.za/psychology/engels-web/couns-gen-info-htm)) says:

*Counselling psychology is a specialised field within psychology which focuses on developing the person in individual, family and community context, with the aim of acting preventatively and/or therapeutically. Counselling psychology is also concerned with the development of human potential. The central aim is to improve the quality of life of individuals and groups.*

Counselling psychology's aim of "acting preventatively" is crucial in HIV/AIDS counselling, where one of the major focus areas is prevention of transmission. But, therapeutically, it is suspect, since the person will be on the brink of death; hence, a more reassuring approach is needed. Therefore, we suggest pastoral or hope therapy as more appropriate (discussion later).

But how do pastoral counselling and counselling psychology differ? Pastoral counselling parts ways with psychology when it comes to the central aim. Christian or pastoral counselling aims at mature faith and spiritual development while, as stated above, psychology vaguely refers to the quality of life. If happiness imparts "quality of life", then psychology makes one wary. It has a mammoth task to achieve when a person faces death. In the HIV/AIDS situation it is arguably the spiritually mature who live doxologically - the product of pastoral counselling.

The four broad approaches to counselling psychology are: psychodynamic, behavioural, humanistic and existential (Miller and Jackson 1985:68). However, it would be naïve and unwise to think that choosing one approach would solve humanity's complex problems. There is no single ideal method that can solve all counselling problems, but a counsellor should develop an organised way of thinking, tapping all the approaches. A counsellor should adopt the following

processes: be flexible, eclectic, practical, pragmatic and differential.<sup>2</sup> However, although any counselling should tap the other approaches, it is very important to maintain the distinctiveness of pastoral counselling. Therefore, let us briefly discuss the different pastoral counselling approaches with regard to psychology, which all have an influence on HIV/AIDS counselling.

### 5.2.3 Different models for pastoral counselling

The relationship between the psychological and the biblical approach to counselling can be described in two ways: psychology in opposition to a biblical approach and an integration of the two.

#### 5.2.3.1 Psychology: In opposition to a biblical approach?

The proponents of this view argue that Christianity opposes psychology. They see little or no value in psychology, and thus reduce all problems to the spiritual arena (Meier *et al.* 1991:26). Jay E. Adams classically represents this view.

In *Competent to Counsel*, Adams (1976) describes how he found psychology/psychotherapy not useful. He argues that the more he tried to use psychology, the more he found it useless. But, while reflecting on Scripture, he discovered that the Bible actually says and contains much information regarding psychological issues. In designing his model, Adams applied the following presupposition: the Bible is inerrant and is the only standard of faith and practice. It is the only criterion for judgement.

To show the extent of his opposition to psychology Adams (1976:15) called Freud “an enemy not a friend”. He named his own counselling approach “nouthetic confrontation counselling”. The Greek words *nouthesis* (the noun) and *noutheteo* (the verb) are the forms in the New Testament from which the term “nouthetic” derives (1976:41). He argues that the New Testament urges Christians to confront one another nouthetically.

Adams perceives three elements in *nouthetic* confrontation. The first is when something is wrong, some sin or some problem needs to be acknowledged and

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<sup>2</sup> Miller and Jackson 1985:69.

1. Flexibility - thinking that is open to new ideas rather than being assumption bound, seeking the paradigm to fit the individual rather than forcing all individuals to fit into a single mould.
2. Eclectic - in the best sense, willing to consider perspectives and intervention approaches from a broad range of sources.
3. Practical - helping you to know what to do next.
4. Pragmatic - choosing on the basis of helpfulness, interested in information and research on the relative effectiveness of different approaches.
5. Differential - changing with the individual needs, rather than having a single perspective or intervention approach for everyone.

handled. Nouthetic confrontation then arises from a condition in the counselee that God wants to change. Therefore, nouthetic confrontation is intended to effect personality and behavioural changes. Secondly, nouthetic contact entails personal conference and discussion (counselling) directed towards bringing about change towards greater conformity to biblical principles and practices. Thirdly, nouthetic confrontation changes that in life which hurts the counselees, so that one meets obstacles head on and overcomes them verbally, not in order to punish but to help.

*Nouthesis* is motivated by love and deep concern in which clients are counselled and corrected by verbal means for their own good, so that God may be glorified. While supporting his confrontational approach in *The Big Umbrella*, Adams (1975:9) concludes that some of the causes of people's sickness are that they are not living as God requires, and they are not doing what they should be doing.

Crabb calls this view (psychology being an enemy of the Bible) the "nothing buttery". To Crabb this "nothing buttery model" is a reaction to the "separate but equal" model and the "tossed salad" model. The former fails to recognise the relevance of Scripture to psychological problems, and the latter reluctantly adds Scripture to psychological philosophy, without carefully scrutinising the psychological content in the light of Scripture. The basic premise of the nothing buttery approach is "Nothing but grace, nothing but Christ, nothing but faith, nothing but the Word" (1979:40).

Crabb sums up the philosophy behind the nothing buttery. Firstly, Scripture does not pretend to offer detailed guidance on external physical issues. People should remain within biblical principles and validly turn to medicine and any other secular disciplines without compromising their Christian position. Secondly, proponents of this approach say that everything we need to know to live effectively is included in Scripture, and personal problems that plague people stem from sin. Early childhood or internal psychic structures do not cause any problems. Thirdly, the counsellor needs to know nothing but Scripture in order to deal effectively with every problem, since God's revelation of how He deals with sin comprehensively is as stated fully in Scripture. Fourthly, people are responsible for their behaviour. What happens does not cause psychological problems, but how you respond to whatever happens causes such problems. Fifthly, they view counselling as involving identification of the sinful pattern assumed to be underlying whatever problem surfaces, then exhorting and guiding the person to deal with this pattern by confession and definite repentance, reflected in changed behaviour.

Adams's *nouthetic* confrontation (nothing buttery) strongly insists on the centrality of Scripture and emphasises personal responsibility, which is a welcome relief to those who excuse sinful behaviour. HIV/AIDS (as discussed in

Chapter 2) is in effect the result of irresponsible sexual behaviour, especially in Sub-Saharan Africa where it is largely linked to heterosexuality (Greyling and Murray 2004: 3.4/19). But their insistence that psychology has nothing to offer and their counselling model whereby you “identify sin and command change” is reductionist. What if a faithful spouse is infected by an unfaithful one? Has he/she committed a sin? This simplistic approach to counselling (i.e. finding sin and exhorting change) fails to reflect the essential dynamic of Christianity and does not fit the realistic situations of counselling. In fact, it leads to apathy and indifference towards the person with HIV/AIDS, since he/she is viewed as a sinner, which leads to discrimination and stigmatisation. Thus our argument for *koinonia* counselling in which the person living with HIV /AIDS is approached in terms of grace leading to empathy and acceptance breaks down. The faith community (*koinonia*), instead of identifying with the person and being involved in bringing healing, becomes apathetic, which leads to isolation and rejection – hence aggravating the pain. Thus a wise and qualified biblical counsellor should not stick uncritically to the Adamic approach, but should tap knowledge wherever he/she can find it and knows how to approach each individual with that truth in a way that focuses on God.

The value of Adams’s *nouthetic* approach, which Crabb calls nothing buttery, however, should be noted. No person can claim to be a pastoral or Christian counsellor if he/she does not study Scripture. A Christian counsellor should be saturated with Scripture. And the need for Scripture is even greater in HIV/AIDS counselling, where the disease is complex and ethical dilemmas surface regularly. Church members who are the caregivers should do intensive Bible studies and attend seminars on how to use Scripture contextually. This approach, however, might contain the danger of condemning HIV/AIDS-infected people as sinners, if an immature person practises it. *Nouthesis*, as Adams rightly argues, is motivated by love and concern for the affected individual, which should lead one to identification and empathy. Thus the danger in Adams’s approach could be reduced by the motivation of love.

In *A Mature Faith*, Louw (1999:28-30) outlines what he calls “the kerygmatic model,” which is dominated by the Reformed view. This model shares some similarities with the Adamic approach. It approaches human beings from a point of view of fallibility. Human beings are sinful and they can only be liberated by Christ’s expiatory death. The reality of sinful brokenness underlies all human problems. Restoration is beyond human ability, but is possible only through Christ’s redemption. In fact, the message of salvation restores human beings to new people and guarantees redemption from sin. Thus the kerygmatic model, Adams *nouthesis* as well as Crabb’s nothing buttery operate from the same presupposition. But Louw warned that this model holds the danger of elevating the Fall, thereby distorting creation in a very negative and pessimistic way. Luther and Calvin held to this model and it is highly

criticised for failing to address humans' inner potentials and abilities. And the emphasis on proclamation can degenerate into kerygmatic enforcement and manipulation. Furthermore, although humans are sinful, we cannot ascribe all problems to sinfulness. Thus if suffering, especially HIV/AIDS, is the result of sinfulness, what explains a faithful spouse becoming HIV infected by an unfaithful partner? This approach therefore, though valuable, is problematic in the reductionist way in which it is presented.

The above approaches, as argued, are undoubtedly valuable to Christian counselling, but they lack serious engagement with human existence. Hence, any model that overlooks human existence – especially the African HIV/AIDS situation – becomes alien to humanity. Clinebell (1984:50) wisely asserts, “The biblical truths are illuminated by being applied and tested in the arena of human struggles and growth”. Therefore, HIV/AIDS counselling requires practical models that are usable and can be adopted in home-based care (see Chapter 6). However, while Adams's approach, the nothing buttery and the kerygmatic models lack serious dialogue with psychology, I should ask: how then should the Bible and psychology be integrated in pastoral counselling?

#### *5.2.3.2 Biblical and psychological counselling: an integrative approach*

Some Christians become wary when they hear the word “integration”. It is normal to feel so because “integration” suggests blending the Bible with psychology “half-half.” Meiers *et al.* (1991:29) warn that “there is a danger in adopting this model uncritically. Integration can easily become syncretism, a mixing of paganism and Christianity to produce a sub-Christian, compromising faith”.

Nevertheless, the value of psychology should not be underestimated. Miller and Jackson's (1995:16) description of the place of psychology is timely:

*God also has given to humankind the gift of reason and through it the marvellous healing techniques of modern medicine and psychology. We view such secular technology as a set of tools, to be employed within any faith system that does not exclude it.*

Crabb (1979:32) also argues for the place of psychology in Christian counselling, saying that there are certain problems that Christians have that have nothing to do with spirituality. He illustrates this fact by asking:

*How do you promote obedience to character growth in someone who complains of snakes, which interfere with family camping trips? Do you discuss his biblical responsibilities to his family and exhort him to go in spite of his fear, trusting God for protection and peace? Or do you use the behaviourist technique of systematic desensitisation, a secular technique with fairly well documented effectiveness?*



The argument may also apply to medical doctors who may be unbelievers, but are helping people. Thus if psychology offers insights that increase our counselling effectiveness, we should adopt them. But if problems are spiritual, we must not neglect the resources that we have through the Lord and Scripture by wrongly over-emphasising psychology.

The challenge that Christians face, however, is how to synchronise the inerrant, inspired Word of God and the vast literature of theories and observations of secular psychology. At the heart of Christianity is the centrality of Jesus Christ, as revealed in Scripture, and at the heart of psychology is humanism, a doctrine which adamantly insists that humans are the highest beings. Therefore, in attempting to address this paradox, Crabb proposes four approaches.

- ≈ Firstly, “**separate but equal**”. This view holds that Scripture deals with spiritual and theological problems involving Christian beliefs and practice. Areas of legitimate concern, such as medical, dental and psychological disorders, are beyond the range of Christian responsibility and qualified professionals should deal with them (Crabb 1979:34). These people vehemently argue that the Bible was/is not a textbook of psychotherapy or medicine; therefore, if a person has a problem he/she should visit the appropriate professionals.

Holders of this view assume that emotional problems have no relevance to spiritual problems. This misinformed conclusion does not recognise that some psychological malfunctions are a result of guilt, anxiety, resentment, uncontrolled appetites, lack of self-acceptance, feelings of personal unworthiness, insecurity, wrong priorities and selfishness. And it does not require a top theologian to see that Scripture addresses these issues, e.g. the Psalms. Such a naïve wall between Scripture and psychology should be dismissed as an inaccurate teaching and understanding of Scripture.

- ≈ Secondly, “**tossed salad**” (Crabb 1979:35). This approach to integration resembles “the strategy followed in preparing a tossed salad, i.e. mixing several ingredients together in a single bowl to create a tasty blend”. This model claims that Christianity offers great and, at times, indispensable truths (e.g., faith, love, hope, trust, purpose). And when the cream scriptural and psychological insights are mixed, effective Christian psychotherapy emerges.

In this integrated design the model aligns the two disciplines of theology and psychology to determine the subject matter that overlaps and then blends the insights from both disciplines. Crabb illustrates the point this way: the process is much like bringing together two complicated halves of a jigsaw puzzle to complete the puzzle. For instance, harmatology (study of

sin) and psychopathology (psychological study of mental deviance) both deal with human distress from different perspectives. In a tossed salad model, harmatologists and psychopathologists are put in one room to compare their notes and arrive at a synthesised view of the human predicament.

The problem with this model lies in its de-emphasis of careful screening of every secular concept in the light of Christian perspectives. Psychology operates from secular presuppositions based on the subjective interpretations of data with no objective truth, while Christianity operates from a set of objective truths revealed in Scripture. We must scrutinise psychological information in the light of Scripture. We must do more than just mix a tossed salad by matching concepts from two disciplines into a synthesis, allowing the concepts fidelity to their own presuppositions. A classical example of this model's snare is Transactional Analysis (TA).<sup>3</sup> Morality can be reduced to an insistence on adult behaviour, including sin as part of our childishness, and treating material from our conscience (parent) as suspect.

The critics of the tossed salad integration do not discredit psychology, but warn Christian counsellors against careless acceptance of secular ideas that may lead to an unplanned compromise with biblical doctrine. Integrationists should screen secular concepts through the filter of Scripture, then align them with appropriate theological matter and assimilate them congruently.

- ✎ The third model is the “**nothing buttery**” already discussed under psychology as an enemy of the Bible.
- ✎ Fourthly, “**spoiling the Egyptians**”. The carelessness of the ‘tossed salad’ in its treatment of psychology and the overreaction of ‘nothing buttery’ pushes people to “spoiling the Egyptians”. This phrase is from the Exodus incident (Ex. 11), when God instructed Israel to take articles (as spoils) from the Egyptians. However, Crabb hastens to warn counsellors of the dangers of taking spoils. He says that, as Israel left Egypt, there was a mixed multitude that eventually led Israelites in the wilderness to rebellion. His concern is clear about the “tossed salad” and can hardly be over-

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<sup>3</sup> Crabb (1979:38-39) Assumptions specified as underlying TA in *I'm OK-You're OK* by Tom Harris.

1. God is an impersonal force (Harris accepts Tillichian theology).
2. Man is basically OK. Sin is nothing more than the unfortunate, learned conviction that 'I am OK.' There is no room in TA for objective, moral guilt.
3. Redemption is the process of discovering that many painfully negative self-assessments are not and never have been true. I am really OK. Acceptable exactly as I am. The position parallels universalism with its teaching that all people are OK, although some suffer under the fear that they are not.
4. Man is sufficient to himself.

emphasised. The temptation is for one to examine Scripture through the eyes of psychology, yet the opposite should apply (i.e. viewing psychology through the eyes of Scripture).

Crabb (1979:49-50) lists the qualifications for a truly evangelical integration of Christianity and psychology in the following ways. Firstly, psychology must come under the authority of Scripture. This means that, when the teaching of Scripture contradicts other ideas, Scripture will be accepted as the truth. Secondly, the Bible is God's infallible, inspired, inerrant revelation in proposition. Thirdly, Scripture should have functional control over thinking. "Functional control" means that the principles of biblical priority over contrary non-biblical opinion are not merely a doctrine to which one swears allegiance, but are actually put into practice thoroughly and consistently. Fourthly, functional control of Scripture can be achieved over psychology by spending as much time with Scripture as students of psychology do on their subject - studying the Bible systematically to grasp the overall content, to have a working knowledge of the basic Bible doctrine, and profit from the Spirit's gifts through fellowship in a Bible-believing church.

Crabb adds that psychologists have discovered useful insights, but sometimes use them according to wrong assumptions. Therefore, "spoiling the Egyptians" of secular psychology, carefully weeding out the elements which oppose Scriptural revelation, would equip a counsellor well.

Crabb makes a significant contribution to the understanding of the place of psychology in Christian counselling. However, an immature Christian response as a "tossed salad", which he tries to avoid, could easily be confused as "spoiling Egyptians".

- ✧ Adopting a different approach, however, Louw (1998:34-36), in *A Pastoral Hermeneutics of Care and Encounter*, handles this dilemma of integration as a tension. He describes the "bipolarity" (i.e. tension) that exists between the two forms of knowledge as health. The Reformed model (i.e. the kerygmatic model) and the directive and confrontational model (nouthetic counselling) are on one side, while the client-centred or empirical model (phenomenology and experience/observation) is on the other.

The kerygmatic model emphasises admonition and the conversion of sinners by the kerygmatic proclamation of the Gospel. Pastoral care is "viewed as the offer of redemption to sinners through the therapeutic process involved in forgiveness and care of the soul" (Louw 1998:25). Adams's model of counselling, i.e. directive and confrontational, views counselling as the task of confronting sinful behaviour and directing a person through Scripture. These

two models reveal the dominant role of God's Word as an instrument of conveying God's grace.

On the other hand, we have the client-centred model rooted in a Rogerian non-directive approach, in which the counsellor gathers (educes) knowledge from the client by means of perception and empathy. People become their human documents/text. The structure of communication dominates the scriptural text. Therefore, Scripture, Gospel and revelatory Theology are in tension with psychology, existence, experience and empiricism. Louw calls this tension a "bipolarity".

However, this bipolarity reveals a healthy tension between the different sources of knowledge. One source is from above and the other from below, and the two will never merge. Louw (1998:37) puts it thus:

*The bipolarity is a healthy tension between revelation and human existence, between God's presence and human suffering and struggle. Bipolarity is part of the tension between content of faith (fides quae) and the existential modes of faith behaviour (fides qua).*

Therefore the tension should not be dissolved by synthesis. He adds that the God-human mutuality should be interpreted hermeneutically, in terms of the dialogical structure of the God-human encounter. This bipolarity cannot be explained in purely rational terms, but by paradoxicality. The classic example of this paradox is seen in the cross. In human logic, experience and empirical perception, it seems as though God does not care and is absent in the cross. But viewing the same scene from a faith dimension, there is gripping knowledge of God's faithful presence and compassionate love. As a result, the cross becomes a symbol of both the presence of God and of his identification with our suffering.

In designing a pastoral care and counselling model, in our case HIV/AIDS counselling, Louw argues that the theological reduction of human problems in the kerygmatic model; the psychological reduction of human problems in the empirical or phenomenological (client-centred) model; the danger of complementarism in the bipolar model, i.e. God and humans being viewed as equal partners totally complementing each other, which Crabb calls the tossed salad, are completely unacceptable. Therefore, only a convergence model can adequately address the bipolarity (tension).

≈ The **convergence model** views pastoral care and counselling as a unique theological perspective, i.e. eschatology, determines it. Eschatology signifies the essence of our new being in Christ, as well as the revelation and fulfilment of our future in terms of the coming kingdom. Louw (1998:59) describes eschatology as follows:

*Eschatology is not only a description of the end of history, but also reveals the essence of our new being. Eschatology defines the theological stance of pastoral care in terms of the cross and resurrection.*

In the convergence model eschatology then implies that the meaning imposed by pastoral care is inevitably connected to hope. Therefore, the exercise of pastoral care is a sign of hope to the world. This hope is the fountain of peace and the motivation to live in this life, even living with HIV/AIDS. And within *koinonia* the eschatological dimension promotes responsibility towards one another and the hope that is lived is shown and practised to fellow human beings.

Eschatology, as the basic principle for the design of the convergence model, links together death and life, fear and hope.

- ~ The component of death and dying: in the expiatory death of Christ, “We were therefore buried with him through baptism into death” (Ro 6:4);
- ~ The component of resurrection and life: “We have been resurrected from death with Christ” (Eph 2:6), also 1 Corinthians 15:17-20. A life that is founded on the hope of resurrection will provide a continual process of faith development and growth. The hope of the resurrection destines the Christian life’s story for victory and imparts a future dimension to faith. Without this future dimension, pastoral ministry loses much of its therapeutic dimension: hope based on the fulfilled promises of God (Louw 1998:59).

The convergence model, which operates within the principles of eschatology and perspectivism, recognises that there is a tension between the “already” of our salvation and the “not yet” of the coming kingdom. The past, i.e. the history of God’s salvific grace, determines the now, i.e. our human existence. The future, i.e. the not yet of Christian hope, also determines the now. Therefore, pastoral care operates from the perspective of life and hope. The Holy Spirit empowers life and emanates from the victory of the cross. The Holy Spirit, who is the Counsellor, guides Christians. Hence the Holy Spirit (pneumatology) is central in the convergence model.

In *The Holy Spirit and Counselling*, Anderson (1985:264) defined the Spirit as “the activating or essential principle influencing a person”. He adds that the Holy Spirit implies existence without material substance; on the highest plane, the Spirit is called God. The Spirit serves to lighten the burden experienced by those counsellors caught up in consciously identifying with their counselees, bearing their loads, taking their steps for them, and finding themselves emotionally and physically exhausted in the process. All in all, the Spirit

mediates the counselling conversation in an unseen way, which Louw calls a “trialogue”.

Pastoral/Christian therapy is closely linked to the Word of God. When understood from a faith perspective, the Word of God becomes part of the pastoral encounter. Louw hypothesises that the communication of the Gospel through pastoral dialogue creates a horizon of meaning, which in turn equips people to deal with life issues in a constructive manner. The teaching in Scripture that reveals the eschatological perspective operates on the presupposition that a crisis of faith surfaces when people live without a horizon of meaning.

In summing up the eschatological perspective for pastoral care as the heart of the convergence model, Louw (1998:65-66) makes several key points about the eschatological model.

- ☞ It provides a horizon of meaning. Eschatology refers to God’s fulfilled promises regarding salvation; therefore, it addresses the most fundamental human need for restoration, peace, integration and conciliation.
- ☞ It links the believer to the faithfulness of God. The believer is offered a guarantee of God’s presence in the midst of uncertainty, discontinuity and the paradox of life. Life attains a measure of stability and security, which is essential for healing, help or therapy that is offered to people.
- ☞ It creates a normative framework: a meaningful life needs norms according to which to live. The eschatological perspective criticises human complacency, selfishness and loveless self-assertion. The normative framework, created by an eschatological perspective, distinguishes the theological base theory in pastoral theology from empirically designed theories. Theories from human sciences, philosophy and anthropology, when incorporated into pastoral practice, should not distort the fundamental aspects of faith behaviour: trust in a transcendental factor; self-sacrificing service; unconditional love; hope for the future and grateful, joyful life. The eschatological perspective creates the framework in which these aspects of faith behaviour become decisive.
- ☞ It imparts a unique identity to the pastoral act itself. The pastor acts from a faith dimension. The eschatological perspective also distinguishes personal identity from spiritual identity. Spiritual identity results from the blending of faith and grace, but without excluding reason and self-actualisation. The faith dimension defines pastoral care as a unique discipline. Pastoral care is linked with the principles of the Gospel.

In this section pastoral counselling has been discussed in terms of its relationship with psychology. It has emerged from Crabb’s models that the “separate but equal”, “tossed salad”, and “nothing buttery” weaken the effectiveness of pastoral counselling and, at worst, they distort and dilute it;

hence, it loses focus and uniqueness, and “spoiling the Egyptians” should be recommended. But Crabb’s “spoiling the Egyptians” is a clumsy approach that can easily be confused with the “tossed salad”. Therefore, in designing HIV/AIDS pastoral counselling, psychological approaches should be scrutinised in the light of biblical teaching. Furthermore, in the light of Louw’s models, the reductionist one-sidedness of the kerygmatic and phenomenological approaches should be avoided. The perspective model, with its eschatological focus and orientation, is recommended.

However, though Crabb’s spoiling the Egyptians is an invaluable model, for this research Louw’s convergence model is preferred. It has direct implications for the *koinonia* care and counselling approach that we are advocating. The eschatological perspective of the convergence model places responsibility for care on the faith community (*koinonia*). Eschatological beings have ethical responsibility. Since eschatology signifies Christians’ new being in Christ (i.e. people of the kingdom), it means *koinonia* care (pastoral care) should be a sign of hope to the world. Christians should demonstrate the love and compassion that is much needed by those affected by HIV/AIDS. Wilson *et al.* (1996:195) are right in stating that genuine Christian community is more than just mutual acceptance and respect, but members share their lives with each other, give attention to each other and care for each other, especially in times of need. The other important central element of the convergence model, the Holy Spirit, transforms Christians’ apathy so that they become well disposed towards affected people. And even though the burden of HIV/AIDS care may be unbearable, the Spirit lightens up the burden experienced by the caregivers who identify with the affected people.

In summing up the role of psychology in pastoral counselling, I would discourage any model that disregards psychology, such as the nothing buttery, or deals with human being’s problems in a reductionist manner. The evidence and arguments “for” psychology outweighs those “against”. Therefore we contend that pastoral counselling should integrate psychology with the Bible. However, the integration should be healthy. The uncritical scrutiny of psychology, such as complementarism or the “tossed salad”, should be avoided. Psychological information should be scrutinised in the light of Scripture. The recommended integrative approaches therefore are “spoiling the Egyptians” proposed by Crabb and the convergence model proposed by Louw. But of these two models, the convergence model is preferred. It clearly maintains the bipolarity between the two sources of information (Scripture and psychology) and resolves the tension through perspectivism, while “spoiling the Egyptians” can easily be confused with the tossed salad.

Furthermore, the convergence model as an integrative model highlights and strengthens our argument for a church system (*koinonia*) approach to care and counselling through the notion of the eschatological nature of Christians. New

life in Christ entails disposition and identification with those in pain as part of God's family. The new life is not lived in isolation, but in a community with other believers. Thus our preference for a convergence model has direct *koinonia* implications. The eschatological beings are steered to care for one another. This creates a link with the African communal approach, where people care for one another in the community, which is crucial for HIV/AIDS-affected people, who require community acceptance and love.

Thus far I have argued that pastoral counselling should integrate Scripture (Bible) and psychology. But in integration the distinctiveness of pastoral counselling should be maintained. Therefore I pose the following basic question: what is the nature and distinctiveness of pastoral counselling that makes it the appropriate approach to address the plight of HIV/AIDS-affected people, especially in Africa?

### *5.3 Pastoral Counselling within an African Context*

#### **5.3.1 Spirituality: the unique contribution of pastoral care**

Therapists often differ on "the best counselling approach." Therefore they adopt an eclectic approach. But, amid all the available approaches, pastoral counselling distinguishes itself as a therapeutic approach that has a unique ability to bring spiritual healing to people.

In *Introduction to Psychology and Counselling: Christian Perspectives and Applications*, Meier *et al.* (1991:314) list six unique principles of Christian counselling.

- ✧ Christian counselling accepts the Bible as the final authority. Christians are not tossed back and forth and do not rely on their conscience, but they have the Word of God that is valid and defines men's *telos* and purpose.
- ✧ Christian counselling does not only depend on the human will to be responsible, but they have the Holy Spirit that assists them.
- ✧ Although human beings, by nature, are selfish and ignore or hate God, through faith they receive the Holy Spirit, who gives them victory in overpowering their sinful nature.
- ✧ It deals effectively with the counselee's past. Because people's past guilt is forgiven (1 Jh 1:9), they can look to the future (Php 3:13-14).
- ✧ It is based on God's love. God loves us and his love flows through us as we care for others (Ro 12:9-21). A Christian counsellor feels a spiritual relationship to others and helps them to grow in Christ as they solve their problems.
- ✧ Christian counselling deals with the whole person. It recognises that the physical, psychological, and spiritual aspects of humans are intricately related.



Different from the broad and general outline of Meier *et al.*, Clinebell (1984:67-70) identifies three key distinctive characteristics of pastoral counselling.

- ~ Firstly, the heart of pastoral counselling is its uniqueness, its theological and pastoral heritage, orientation, resources and awareness – the awareness of the Spirit of God's omnipresence as the core of reality that influences everything that pastors do, including counselling. The realisation of this spiritual dimension is central to pastoral counselling. Pastors' unique training that orients them to both theology and psychology allows them to deal with humans holistically. The theological knowledge of issues such as life after death helps to impart meaning to people.
- ~ Second is the pastoral counsellor's working premise. Spiritual growth is an essential objective in all caring and counselling, which is uniquely pastoral. The counsellor's goal is to foster spiritual wholeness as the core of the whole person. And in all that the counsellor does, spiritual growth is central.
- ~ The third unique feature is that pastoral counsellors are expected and are (hopefully) trained to use the resources of their religious tradition as an integral part of their counselling. In addition to prayer and Scripture, most of the church tradition rooted in Scripture can bring healing, if used well. The setting and context of pastoral counselling, which is ecclesial, places the counsellor in a unique position to assist people. The daily network of relationships, and the accurate knowledge of church members' lives, allows the counsellor to intervene at any time when he/she notices a problem. This certainly places pastoral counselling a notch above secular counselling, which only operates on the basis of what the client says during the counselling session.

Crabb (1979:20) captures the difference/uniqueness of pastoral counselling by focusing on its goal. He says that when people experience problems, they place "top priority not on becoming Christ-like in the middle of problems but on finding happiness". However, it should be noted that the goal should not be happiness (as psychology may claim), but to respond biblically by putting the Lord first (spiritual maturity), and to seek to behave as He would want us to. As we devote all our energies to the task of becoming what Christ wants us to be, He fills us with unspeakable surpassing joy and peace, beyond what the world offers. Therefore, the goal of Christian counselling is to encourage one to become more Christ-like (maturity in faith), and the by-products will be eventual peace, healing and happiness. The reason why people seek to have obstacles (problems) removed from their way should be to promote worshipful life, i.e. so that they will be able to worship God more fully and serve Him more effectively. Crabb (1979:22) summarised the goal of Christian counselling simply as "to free people to better worship and serve God by helping them become more like the Lord. In a word, the goal is maturity".

Maturity is both spiritual and psychological. For one to become psychologically whole and spiritually mature, one must understand clearly that one's acceptability to God is not based on one's behaviour, but rather on Jesus Christ's behaviour (Tit 3:5). Although people remain sinful, Jesus' perfect life justifies them. Justification brings self-acceptance, as people regard themselves with the understanding that they do not need to do anything to be acceptable, because Christ did everything for them. As a result, all the attention is paid to the God of Scripture as the only Person to be pleased. "The foundation of the entire Christian life then is a proper understanding of justification" (Crabb 1979:24).

Christians' final destination is glorification, which is also entirely God's work. But, between justification and glorification (eschatology - now and not yet) is the life we are living (the life of obedience empowered by the Holy Spirit). During the present times people stray from the path of righteousness and do not follow biblical patterns. Therefore, Christian counselling is concerned with whether the person is responding biblically in whatever situation he/she experiences. Regardless of the situation or background, God's faithfulness assures us that the client/counselee has all the resources that he/she needs for learning to behave biblically in the particular situation. "A counsellor must help the client to move OVER to the pathway of obedience" (Crabb 1979:26). "Moving over" entails removing roadblocks in the journey, such as "I can't" or "I won't". Helping a client to "move over" is part of the goal. However, a Christian should go beyond behavioural change. Crabb (1979:27) writes:

*Attitude must change, desires should slowly conform more to God's design, and there must be a new style of living .... The change must not be only external obedience, but also an inward newness, a renewed way of thinking and perceiving, a changed set of goals, and a transformed personality. I call this second, broader objective the up goal. People need to move not only OVER but also UP.*

Psychology, however, disregards this phenomenon of moving OVER to biblical conformity and rising UP toward an attitude of Christ-like submission to God's will. But pastoral counselling focuses on it, which underlines its unique contribution. In HIV/AIDS counselling, therefore, where death is pending and the person experiences guilt and despair, one should emphasise God's acceptance and unconditional love. Thus the people involved in HIV/AIDS counselling should be sensitive to spiritual needs that should be addressed by means of communicating the Gospel. If HIV/AIDS-affected people view themselves as acceptable before God, and entrust themselves to God's hands, healing may occur. These people would have "moved over" and now think biblically. The process of "moving up" would have started.

Apart from the “moving over and moving up” movements that Crabb emphasises, Louw (1998:258) further clarifies the nature of pastoral counselling in four ways:

- ✧ The Word and the Spirit are a third factor in pastoral counselling, thereby establishing the dialogue as a triologue;
- ✧ Pastoral counselling is essentially a hermeneutical process of interpreting and understanding the Christian faith within human contexts;
- ✧ The covenantal character of the communication between God and humankind implies that parishioners are being approached by the pastor in terms of grace and love (*agape*);
- ✧ In pastoral counselling, a pastoral diagnosis deals with a very specific issue: the association between God images, faith development and growth (maturity). It assesses the value of faith in the human quest for meaning.

Thus the six unique principles of Christian counselling of Meier *et al.*, Clinebell's distinctive characteristics of pastoral counselling, and Crabb's unique points of pastoral counselling can be summed up by Louw's clarification above and the seven points<sup>4</sup> that he summarised, which allude to the description of the nature of pastoral counselling above. But the question I ask is: what is the relevance of the unique characteristics of pastoral counselling to *koinonia* (systems) approach to care and counselling?

Meier *et al.*, Clinebell and Louw point out that the context of pastoral counselling is the community of faith (*koinonia*). God's love flows through the believers as they care for one another (mutual care). A Christian counsellor feels a spiritual relationship to others and helps them to grow in Christ as they solve their problems (Meier 1991). Pastoral counselling therefore implies that believers who experience God's love and grace share it with others. In such a context of a “love bond”, acceptance and oneness are fostered, which encourages mutual care. Those who are living with HIV/AIDS are accepted and

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<sup>4</sup> - The content (what) of pastoral counselling is determined by the notion of salvation and the dynamic influence of God's promises in Scripture.  
- The source of pastoral counselling is the Spirit, who communicates the faithfulness of God.  
- The counselee (who) of pastoral counselling: parishioners as well as all people in need and created in the image of God.  
- The reason and motivation (why) for pastoral counselling: the compassion of God, the Father, the reconciliation of Jesus Christ, the Mediator and consolation of the Holy Spirit provide the motive for the pastor's involvement in counselling.  
- The attitude (how) of pastoral counselling: *agape* love, as exercised through priestly compassion and real charity.  
- The 'objective' of pastoral counselling: mature faith, a vital hope and the disclosure of significance and meaning.  
- The environment and context (where) of pastoral counselling: the *koinonia* within the fellowship of believers (*communio sanctorum*) and the social and public context. Pastoral counselling should therefore manifest and represent in a very symbolic way the mutual care of believers as well as the compassion of God (Louw 1998:259).

become part of the Christian family. This ecclesial context, Clinebell adds, places pastoral caregivers and counsellors in a unique position to assist those affected. The daily network of relationships and the accurate knowledge of church members' lives allows one to be there to "intervene" whenever there is need. As Moltman (1993) rightly argues, these "grassroots communities" are uniquely suited to provide meaningful care and counselling through ongoing closeness and connection.

Furthermore, the centrality of grace in pastoral counselling encourages acceptance of people living with HIV/AIDS. The longing of every individual soul, as Louw (2005) argues in *Mechanics of the Human Soul*, is to be viewed in terms of grace. God's grace through his unconditional love should flow to other people. Other members should reassure HIV/AIDS-affected people who fear stigmatisation and discrimination by being gracious to and accepting them unconditionally. *Koinonia* acceptance communicates practically a God-image of God who identifies and cares, which encourages trust and faith (faith and spiritual development) to the affected people.

But how does pastoral counselling proceed? The notion of salvation and the dynamic influence of God's faithfulness determine the content (the what) of pastoral counselling. A counsellor enters into an encounter with total faith in God and with the aim of communicating Him (i.e. by means of the Gospel) to the counselee so that there will be a convergence of his/her need with the voice of the Gospel. Thus the people doing HIV/AIDS counselling should, in their support care and counselling, have the desire to allow these people to experience salvation, because works of compassion are not an end but a means, and a voice of God's kingdom where the fullness of healing and peace are found. Crabb describes this as crossing "over". Shelp and Sunderland's (1987:104) argument is not convincing on this point. They say that AIDS ministry (care and counselling) is "not primarily evangelistic ministry". While the kerygmatic approach to counselling is discouraged, the centrality of Scripture and hope of pneumatology in bringing transformation cannot be over-emphasised. Although Shelp and Sunderland explain that this means that there should not be pressure to convert the person, a Christian counsellor's goal always is spiritual maturity (either implicitly or explicitly) and the first step to maturity is union with Christ (who is the source of hope). At all times pastoral counselling should attempt to communicate the Gospel, which is the healing instrument, since it mediates God's promises. And it should be done within the notion of fellowship (*koinonia*).

The pastoral counsellor, however, should be aware that, although he/she has a responsibility to communicate the message as clearly as possible, it is the Holy Spirit who communicates God's faithfulness and brings change and healing to people. In addition the pastoral counsellor should view all people as created in the image of God, hence they are objects of our unconditional love. This

understanding changes people's orientation and allows them to offer the best care and counselling possible. The motivation would be God's compassion and the reconciliation of Christ, which is practised lovingly. And, in so doing, HIV/AIDS-affected people who may be discriminated against and stigmatised will find hope in God as they embrace his love and grace.

Crabb (1979:16) further argues that, since pastoral counselling is the responsibility of all Christians, then Christian professionals' (especially pastors') functions are twofold: to equip the body and offer back-up resources. He categorises counselling in three ways. Firstly, there is the counselling by every Christian through encouraging, empowering and loving one another. Secondly, pastors, elders and church leaders teach biblical principles of loving to the parishioners. And thirdly, specially trained people deal with counselling and exploration of deeper and complicated issues, which is the role of Christian professional counsellors. Crabb's model of congregational counselling seems very practical and applicable in African HIV/AIDS counselling (see Chapters 4 and 6). The larger community of faith would be involved in home care, as their ability permits, but pastors, elders or specialists from outside should train those who offer themselves for the special home-caring ministry. Leadership should facilitate this.

In summary, I would emphasise that pastoral counselling is distinguished from psychological counselling as follows: its context is the faith community/congregation (*koinonia*), it is done through believers' mutual care, its goal is spiritual maturity and faith development, its motivation is love (*agape*), its content is God's promises in Scripture, the counselees are parishioners as well as all the other people in need, and the source is the Holy Spirit.

Thus far the uniqueness of pastoral counselling and its implications for a *koinonia* (systems) approach to counselling has been discussed. In the discussion and the many other previous sections, the words "healing" or "therapy" have been mentioned. Therefore I ask: how is pastoral healing achieved? Is healing possible for HIV/AIDS affected people? What is the healing function of *koinonia* for people living with HIV/AIDS?

### **5.3.2 Healing and hope in pastoral counselling (therapy)**

Pastoral care and counselling are conceived as a healing art. Healing permeated Jesus' ministry. De Gruchy (cited by Louw 1998:440-441) argues that healing cannot be separated from the notion of salvation. Jesus and the early Christian community's healing ministry was integral for the proclamation of the kingdom. De Gruchy points out that healing in the Bible reflects a holistic understanding of humanity and reality. The concept of *shalom* is about not only the human psychic and physical dimensions, but also the social and political, order. Therefore De Gruchy connects salvation and healing as that

which enables us to be fully human in relation to our society, our environment and ourselves. Both are indicators of healing and humanisation.

In medicine therapy is different from what it is in the helping professions. Medical therapy eradicates pain through medication, while the helping professions are concerned with the treatment or help that is focused on healing and recovery through communication. Psychotherapy, as Tydemann (cited by Louw 1998:442) states, is intended to help the patient to gain insight so that honesty about oneself (self-knowledge) could create an inner knowledge, which sets one free. And in doing this, the counsellor needs genuineness, non-possessive warmth and accurate empathy.

However, there is a clear difference between therapy in psychology and theology. Louw (1998:443) describes the difference thus:

*Psychotherapy concerns a person's personality functions and problems on an intra-psychic, inter-personal and contextual level. Pastoral therapy is primarily concerned with problems on a spiritual level: it focuses on people's functions of faith and their relationship with God. In so far as psychic, relational and contextual problems are at issue in pastoral care, they are connected to belief and the quest for meaning in life. Furthermore, growth and development in theology are not related to inner potential, but to the charismatic potential in the pneumatic person.*

He strongly warns that pastoral therapy does not merely lie in the pastor's Christian faith, a person's biblical view, or the notion of the reality of sin. Neither does it lie in a careless mix/dilution of theology with psychology. Christian therapy, which he terms, "promissiotherapy", seeks to foster the maturity of the whole person. Its objective is spiritual maturity, faith development and growth. "Promissiotherapy is offered by the *koinonia* and is based on theology: God's faithfulness to his promises and the healing dimension of salvation" (Louw 1998:444). Schiller (cited in Louw 1998:444), explains this phenomenon:

*Salvation therapy includes liberation towards eternal communion with the Triune God, as well as a transformed attitude regarding the meaning of human life; a disposition of love for the fellow human being; courage and joy in life in trusting God; and hope for the future which endures throughout the process of dying and death. The therapeutic issue resides in the Christian's life once there is a living and committed relationship with Jesus Christ.*

The context of pastoral therapy is the community of faith. And it has the Gospel's comforting and caring dimension. Pastoral therapy is intensely concerned with the paracletic dimension of salvation.

Therefore, the characteristics of Christian/pastoral therapy, i.e. promissio-therapy, are:

- ≈ It is concerned with the paracletic dimension of salvation;
- ≈ Its context is *koinonia*, the community of faith (fellow-believers);
- ≈ The Gospel is central – God's faithfulness to his promises;
- ≈ Its goal is maturity, faith development and growth.

Louw (1998:448-449) summarises the therapeutic effect of pastoral counselling in five solid statements:

- ≈ **Firstly**, pastoral therapy, as an exponent of grace, is essentially linked to God's faithfulness and his promises. This linkage to God's faithful promises and salvation means that pastoral therapy can be typified as promissiotherapy in terms of its therapeutic effect.

In biblical counselling, the therapeutic effect of promissiotherapy is that God's faithfulness to his promises encourages the growth of faith in the human heart, and that this faith offers certainty and security. Furthermore, faith brings gratitude to the suffering. The communication of God's promises in a concrete way to bring therapeutic effect makes promissiotherapy distinct from psychotherapy. It has a different goal (i.e. faith maturity), effect (reconciliation) and uses different media to generate change (i.e. Scripture, prayer, sacraments). Promissiotherapy, as salvation therapy, focuses on forgiveness and justification by grace as important therapeutic components, which is crucial for the guilt and despair that the person living with HIV/AIDS may be experiencing and the forgiveness he/she requires.

- ≈ **Secondly**, promissiotherapy also engages with the issue of anticipation in our human existence, thereby creating hope in the human heart; promissiotherapy is an exponent of the eschatological stance in theology.

God's promises are not only for the future, but also in the immediate context (already and not yet). Our being in Christ influences our actions as we look into the future. Thus from the disclosure of the HIV+ person's status, one should not focus on the infection, but view him/herself as active and contributing to the society in which he/she belongs. The person should feel life-ness, positive and hopeful, and the *koinonia* should make such people feel so through acceptance.

- ✧ **Thirdly**, while the immediate effect of promissiotherapy is faith, the transformation of human existence to that of a new being - the long-term effect of promissiotherapy - is anticipation and a positive stance in life (God's yes to our being functions). Transformation of faith generates hope and connects life to the fullness of salvation. The eschatological tension between the already and the not yet creates a foundation of expectation which fosters meaning in life.
- ✧ **Fourthly**, promissiotherapy in pastoral counselling creates hope and discloses a future dimension for the believer. Hope discloses a horizon of meaning, wherein the believer may enjoy daily victorious life because of the indwelling power of the resurrection. Christian hope is basically resurrection hope. At a therapeutic level, this hope effects a positive process of anticipation.
- ✧ **Fifthly**, when people's future orientation is obstructed, their horizon is also blocked. A blockage of future orientation and loss of meaning in life is a fundamental factor in all dysfunctional human behaviour.

In Christianity, meaning is not structured around values in life, but around the person of the resurrected Christ. The Christian understanding of meaning in life is the confession of faith: Jesus Christ is the Lord. The confession, "I believe in the resurrection of the flesh", means life is reconciled through the cross, and victorious life through the resurrection. Life, apart from the dimension of eternal life, loses its prime focus and is surrendered to the odour of death.

Salvation therapy, hope therapy and promissiotherapy all refer to pastoral therapy, i.e. God's faithfulness, his promises, and the Gospel's offer of redemption. Perspective (salvation), ontic condition (faith) and orientation to the future (hope) are three similar issues, which clarify the distinctiveness of pastoral therapy from various other aspects. Salvation, faith and hope are responsible for giving meaning to life and energising the person to live meaningfully, purposefully and responsibly, even when living with HIV/AIDS. During the encounter the Christian counsellor is responsible for enfleshing sacrificial love, which is his/her motivation, and the Holy Spirit applies the healing (trialogue). The hope cultivated in the person becomes the spring of life as one lives doxologically.

Pastoral therapy, therefore, one would argue that it effects HIV/AIDS healing. Its healing effect is an invaluable fact. And as has been argued earlier, the congregation (*koinonia*) remains the nucleus of this healing ministry<sup>5</sup>. However, caring is not an end in itself. It aims to communicate the salvific grace of God in Jesus Christ, which is the initial stage of faith maturity and spiritual

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<sup>5</sup> However, for detailed discussion see Chapter 4 on church family system care and Chapter 6 on congregational care.



development. While the caregiver should guard against a kerygmatic approach, the Gospel should be central, since it is the only authentic voice of God's love and grace. Salvation dispels all fears, guilt, anxiety and despair from HIV/AIDS-affected people as they recognise their new relationship with the Author of the universe who is in control. Faith makes them stand up and appropriate God's promises and security in Christ. Hope ignites life into flames of peace, joy, and wholeness as they live positively and doxologically knowing that, although this life may soon vanish, yet greater joy and life are ahead. These people's song will be Philippians 1:21-23:

*For to me, to live is Christ and to die is gain. If I am to go on living in the body, this will mean fruitful labour for me. Yet what shall I choose? I do not know. I am torn between the two: I desire to depart and be with Christ, which is better by far.*

Having seen that pastoral healing is about salvation and pastoral therapy (or counselling) aims at spiritual maturity, faith development and growth, the counsellor should be able to assess these issues in order to offer appropriate counsel. But is pastoral diagnosis/assessment diagnosis possible? What does it entail?

### **5.3.3 Diagnosis and assessment in pastoral counselling**

Pastoral counselling and diagnosis are two sides of the same coin. They cannot be separated from each other. A counsellor needs to determine what the person is experiencing in order provide the appropriate support and counselling. The disclosure of the HIV-positive status to an individual may sound like a death sentence. It triggers unprecedented anxiety, fear and despair. Diagnosis allows a counsellor to determine the magnitude of one's crises and disorientation due to the disclosure of the infection. And in HIV/AIDS pastoral counselling the aim is to remove the roadblocks that obstruct one from developing in faith and spirituality because of the HIV status. However, we should be hasten to add that, regarding HIV/AIDS counselling, the focus should not only be on the infected person, but also on the family members (significant others). Coping with HIV/AIDS to a great extent depends on the quality of support (relationships - family, friends including church members, if one is a Christian).

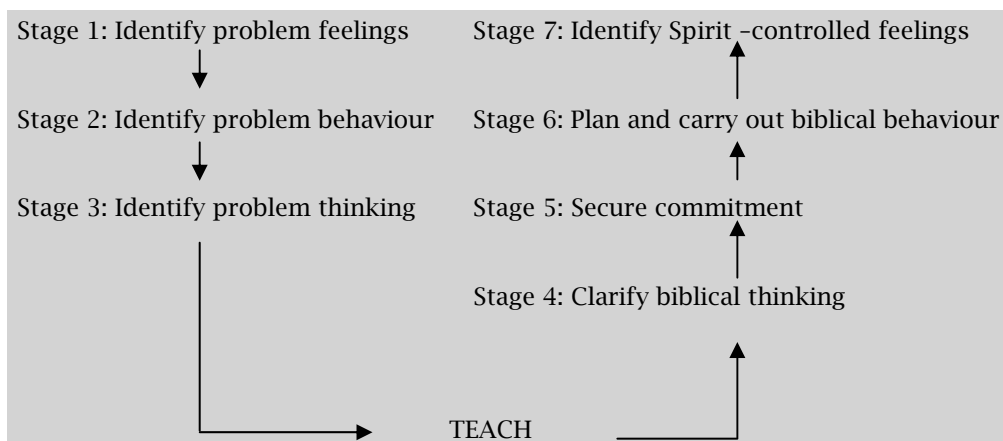
***Pastoral counselling diagnosis focus:*** Pastoral diagnoses seek to understand and analyse the quality of a person's faith and spirituality. Charles Taylor (1991:61-80) calls this process "theological assessment." The events taking place in a person's life are understood from a Christian faith perspective, i.e. eschatology. An assessment of faith is done in terms of God-images and life's ultimate meaning. However, this does not mean that emotions and experiences

are ignored. They are put in a theological frame. In *A Mature Faith*, Louw (1999:23) summarises the meaning of “diagnosis”:

*A diagnosis does not focus on a procedure of classification through which behaviour is categorised and typologised in advance. Diagnosis is simply the interpretation of the person's total existence. It focuses on clarification, establishing connections, organising data and interpreting behaviour in terms of the quest for meaning. Focus on the organising, summarising and interpretation of data enables a pastoral diagnosis to establish links between faith and life; between God-image and self-understanding; between Scriptural truth and existential context.*

In HIV/AIDS counselling diagnosis, the aim is to understand how people respond to their HIV positive status, i.e. what the experiences are that make these people react in that particular way. Thus the counsellor seeks to interpret the person’s understanding of God amid HIV/AIDS.

**Diagnostic models and pastoral metaphors:** Pastoral counsellors have proposed many valuable models and Crabb’s model is among them. His model deserves a detailed discussion, but it will be mentioned only in brief. Crabb (1979:169) identifies seven stages of diagnosis and intervention, as is evident in the diagram below.



The first stage is to “identify problem feelings”. Feelings are a necessary initial focus in order to help the counsellor trace the roots of the problem. Secondly, “identify goal-oriented (problem) behaviour”. After the negative feelings have been identified in stage one, the wrong goals that the person has been pursuing are usually obvious. Thirdly, “identify problem thinking”. Once the wrong thinking has been identified, convince the client that his/her thinking is wrong and present persuasively the biblical route to meet personal needs, as

suggested.<sup>6</sup> Fourthly, “change the assumption or perhaps clarify Biblical thinking”. Commitment to act on the basis of the newly learned assumption then follows, which is critical, because a behavioural change will not flow automatically from changed thinking. Fifthly, “secure commitment”. In the sixth place, “plan and carry out Biblical behaviour”. Lastly, “identify Spirit-controlled feelings”.

Capps (1984:66-69), in *Pastoral Care and Hermeneutics*, lists six diagnostic types in pastoral counselling, which he calls “theological diagnosis”:

1. Theological diagnosis as identifying underlying personal motivations;
2. Theological diagnosis as identifying the range of potential causes;
3. Theological diagnosis as exposing inadequate formulations of the problem;
4. Theological diagnosis as discovering untapped personal and spiritual resources;
5. Theological diagnosis as bringing clarity to the problem;
6. Theological diagnosis that assesses a problem in terms of the deepest intentions of shared human experience.

These six diagnostic approaches are placed in three models of theological diagnosis, i.e. contextual, experiential and revisionist models:

- ∞ The contextual model includes 2 and 4;
- ∞ The experiential model includes 3 and 6;
- ∞ The revisionist model includes 1 and 5.

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<sup>6</sup> Crabb, 1979: 154. Suggestions to changing wrong thinking:

1. Identify where the assumption was learnt;
2. Encourage expression of emotions;
3. Support the client as he considers changing his assumptions;
4. Teach the client what to fill his mind with: The Tape Recorder Technique.

### **Capps's diagnostic approaches and the corresponding pastoral models**

<b>Diagnostic model</b>	<b>Pastoral models</b>
<b>Contextual model</b> Approach to problem: - Causes of problem - Available resources Anticipated disclosure: Resourceful God justifying hope.	<b>Shepherd</b> Praxis: - Views problem in context - Identifies relevant resources Self-understanding: Ministry of competent guidance
<b>Experiential model</b> Approach to problem: - How problem is experienced - How problem may be shared Anticipated disclosure: God, full of grace, supports risk and loving God shares pain	<b>Wounded healer</b> Praxis: - Shares the pain of others - Encourages deeper experience of self and others Self-understanding: Ministry of personal vulnerability
<b>Revisionist model</b> Approach to problem: - Sees problem in a new way - See ourselves in a new way Anticipated disclosure: Perceptive God evoking the truth.	<b>Wise fool</b> Praxis: - Challenges distortions - Encourages new-perspectives Self-understanding: Ministry of basic truthfulness

The pastoral models of shepherd, wounded healer and wise fool depict the role or action that the pastoral counsellor should perform; his/her functions should be eclectic. The shepherd as the guide (Ps 23), and protector (Jh 10) is aware of the range of possible causes of the sheep's discomfort and the resources available for the sheep to cope with life's perils. The wounded healer and the experiential type is rooted in Christ's suffering. He suffered in humanity. The counsellor, as part of humanity, participates in our suffering by sharing experiences in communication. Healing does not come by taking away pain, but by living pain fully. The deeper we go into our painful experiences, the more we experience our common humanity with others and acquire a more profound awareness of God's love. The wounded healer has the same concern as the shepherd, but does not address pain by mobilising available resources. He/she encourages us to live in pain, while the shepherd holds out hope for us.

The wise fool and the revisionist is characterised by simplicity, loyalty and prophecy. According to Paul in 1 Corinthians 3:18, the wise fool is not wise but a fool by the world's standards. He/she is simple in refusing to embrace empty professionalism; loyal in regard to persistent loyalty to others with disregard of self; and prophecy in challenging the accepted norms and conventions in society. The wise fool helps people to see themselves in a clearer light as he/she prophesies by challenging what our institutions are doing; is simple as he/she challenges us to conduct our lives with less self-serving distortion; is loyal as he/she challenges us to be more truthful in our interpersonal relationships. Furthermore, the revisionist model helps us to see life in a new way and revise our ways as the wise fool confronts and challenges us.

Louw (1998:39-54) concurs with Capps's three pastoral metaphor models of shepherd, servant and wise fool. But he adds a fourth metaphor, *paraklesis*. The shepherd metaphor views care as a mode of pastoral ministry. The servant metaphor views the pastor's (wounded healer) therapeutic service as pastoral identification. And by the wise fool metaphor, the pastor stands in a paradoxical relationship to the norms of discernment and understanding. The *paraklesis* metaphor refers to comforting, guidance, direction and advocacy or voicing on behalf of the voiceless as a pastoral mediation of salvation. All these metaphors are valuable as discussed earlier under pastoral therapy, but *paraklesis* seems more suitable in HIV/AIDS counselling in Africa, especially considering the poverty situation. The *paraklesis* applies the Gospel to the person living with HIV/AIDS in despair, thereby bringing comfort and peace. Apart from crucially applying the Gospel to the sufferer, the *paraklesis* advocates for the poor whose rights are not upheld.

In addition, Clinebell (1984:31) proposes the model of holistic growth diagnosis. He views the role of care and counselling as to empower growth toward wholeness in all of the six interdependent aspects of a person's life. The six dimensions are enlivening one's mind, revitalising one's body, renewing and enriching one's intimate relationships, deepening one's relationship with nature and the biosphere, growth in relation to the significant institutions in one's life, and deepening and vitalising one's relationship with God. Diagnosis seeks to determine where there is a problem in relationships in order to foster growth and develop spirituality, which is the centre of the model.

The other model is the life story (narrative) model. Its premise is that past religious experiences influence the way in which a person deals with problems. McKeever's model (cited by Louw 1998:309) is an example of this model. The pastor must hear the person's life story since the problem is embedded within a broader field of historical events. Fowler also proposed the developmental stage model that defines faith in terms of its consequences on human behaviour.

The above models in one way or another reveal that diagnosis in pastoral counselling should consider the criteria that Louw (1998:317) lists below. These criteria can be linked very well to AIDS counselling, which is our focus. However, the question is: why is diagnosis necessary for HIV/AIDS pastoral counselling? People living with HIV/AIDS have to deal with physical crisis,

emotional crisis, relational and communicative crisis, identity crisis, existential crisis and spiritual crisis that should be determined (Porte 2003:6-8).<sup>7</sup>

*Firstly, problem thinking and problem behaviour.* Problem thinking strongly influences behaviour and people's self-esteem. In our case, from the day that one is diagnosed HIV positive, the person may be depressed and stop eating, and he/she may view him-/herself as wasting away and everybody laughing at him/her. As a result, this person's condition deteriorates rapidly. Such ways of thinking should be discouraged and the person should think positively. And thinking positively in Christian counselling is thinking in a biblical way, which results from knowing that a person's self-esteem depends on a relationship with Christ (Crabb 1979:138).

*Secondly, historical context and life story.* Determining the influence of past events within the context of all facts can enable one to understand more about a person's history or life story. Family history, values gained and internalised during the person's upbringing and patterns of interaction within family ties are important pieces of information for understanding faith patterns. However, story is not necessary in HIV/AIDS counselling diagnosis (Christian AIDS Bureau 2004). Asking an HIV person to tell his/her story, especially if the person does not remember the circumstances of the infection, pressurises the person. Besides, where one was innocently infected, this brings unnecessarily painful memories. Therefore, the history of HIV infection should be avoided.

*Thirdly, ego-strength and purposefulness.* This refers to the person's ability to deal with impulses, feelings, needs and significant decision-making. Value systems, goals and their ethical context play a major role in developing discernment and responsible decision-making. Some people break down from the moment they are told that they are HIV positive until death, while others cope easily and positively. Still others commit suicide, or decide to infect many others: "I will not die alone!" Therefore, guidance and confrontation should be

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<sup>7</sup> **Physical crisis** results from physical losses such as the strength or energy to prepare one's own food, personal hygiene, etc., conflict with your body as it fails to do what it used to do, and general loss of weight. HIV/AIDS brings unavoidable torment and distress, which triggers **emotional crisis**. The person has questions about the duration of the disease, as well as about career and family. The person may also interpret everything in terms of the HIV or focus excessively on health. There are also emotions of denial, anger, fear, guilt loneliness, depression and acceptance and resignation. **Relational and communicative crisis** is a result of the negative effect on relationships due to stigma. The person has a fear of being rejected and exposed. The family and social network within which the person lives is confronted by his/her intense emotional behaviour, which may damage relationships. The person also has an **identity crisis** as he/she struggles with personal worth, family acceptance, or redundancy, as he can't do anything besides lie in bed. **Existential crisis** develops as a result of the life-threatening nature of HIV/AIDS. The person doubts the meaningfulness of his/her existence. Dreams, hopes and opportunities for children vanish. The person struggles with meaning. **Spiritually (spiritual crisis)** the person feels as though God has turned against him or her. The person may even think that God is punishing him/her.

the way for people who may be harmful to others. This again proves the value of Christian counselling, since the person will be encouraged to value other humans and not contemplate revenge.

*Fourth, social analysis.* Community structures and the nature and character of existing relations should be analysed for a better understanding of faith behaviour. This is common in Africa, where people live in a network of relationships. If the relationship is not healthy, the person certainly breaks down (this will be discussed further under “African diagnosis” later).

*Fifth, coping skills and temporal events.* There is a link between the past, present and future. The person’s ability to anticipate future-oriented behaviour and goals should be studied to determine to what extent faith has a constructive or destructive function. The person in Christ living with HIV/AIDS has eschatological hope that latches this person onto high hopes and positive living.

*Sixth, interplay between motive, need and expectation – vocation.* The person’s level of motivation, as well as basic needs, role expectations and tasks should be analysed. The person living with HIV/AIDS undergoing Christian counselling should align his/her needs in line with Scripture, as Crabb points out.

*Seventh, the ethical dimension.* This refers to the role that norms play within the level of a person’s moral awareness and conscience. In a pastoral diagnosis a mature faith also examines the ethical dimension of the growth of faith. Even in HIV infection, the ethical person seeks to preserve the lives and safety of others, which should be the product of the HIV/AIDS counselling approaches.

*Focus areas for faith assessment:* Effective pastoral counselling requires a focus. It is important to know the root cause of any problem. Louw designed a chart that aims at the following important pastoral categories: a mature faith - an analysis of faith; commitment and practice - religious analysis; God images - theological analysis of God concepts; and experiences of God.

An analysis of faith would seek the suffering person’s responses in his/her situation regarding the following: the intensity and degree of suffering; negativity and feelings of guilt; the quest for meaning; maturity in faith; belief and content of faith, assessing faith types; a test of virtue. Questions regarding the situation are asked and responses are analysed.

Religious analysis seeks to determine the character of parishioners’ commitment, i.e. practices and rituals. Religion can be dysfunctional, e.g. artificial religion (religion as superstition); conventional religion (religion as tradition); legalistic religion (religion as duty); neurotic religion (religion as an obsessive factor for perfection); and pathological religion (religion as an alienating factor). Religion can also be constructive, i.e. mature religion

(religion as doxology). In this case religion fosters purposefulness and responsible action.

Theological analysis of God images seeks to assess the person's understanding of God by determining the content of his/her God images. These develop through a person's experiences of God in real-life events and by reading Scripture. However, when diagnosing people, counsellors should recognise that they have their own image of God based on their own experiences; they have an ecclesiastical tradition; they should be sensitive to the counselee's concept of God; and the diagnosis should not be ethical, i.e. be concerned whether it is bad or good.

As the person tells his/her story, the counsellor should do a story analysis of God images, i.e. funny stories, tragic stories, romantic stories, ironic stories, dramatic stories and therapeutic stories (Louw 1998:332). Apart from the story analysis, there are four assessment models, i.e. the metaphorical model, the experiential theodicy model, the pastoral semantic model, and the thematic model. The counsellor can choose to use any of the models, depending on the circumstances that the counselee faces. For instance, the experiential theodicy model would be best in crisis counselling.

Christian counselling, however, cannot and does not claim to solve all human problems. But its purpose is for a person to develop the most effective Christian/biblical way of responding in trying times, by applying faith sources in order to live more purposefully and meaningfully with suffering and pain. Drawing from Taylor's *metanoia* model, Egan's model and the anthropological foundation of humans, Louw (1998:355) designed a stage model for the strategy of pastoral counselling (as represented below).

	Stage 1	Stage 2	Stage 3	Stage 4
<b>Purpose</b>	<ul style="list-style-type: none"> <li>- Build contact (trust)</li> <li>- Self-insight</li> <li>- Self-disclosure</li> </ul>	<ul style="list-style-type: none"> <li>- Problem analysis</li> <li>- Paraphrasing</li> <li>- Integration of information</li> <li>- Development of perspective</li> </ul>	<ul style="list-style-type: none"> <li>- Responsible behaviour</li> <li>- Decision-making</li> <li>- Goal setting</li> <li>- Programme designing</li> </ul>	<ul style="list-style-type: none"> <li>- Organic use of Scripture</li> <li>- Discovery of meaning</li> <li>- Awakening of hope</li> <li>- Maturity in faith</li> </ul>
<b>Anthropology</b>	Affective	Cognitive	Conative	Normative
<b>Human function</b>	Experience	Reflection	Decision, action	Believing Hoping
<b>Response</b>	<ul style="list-style-type: none"> <li>- Empathy</li> <li>- Support</li> <li>- Probing</li> </ul>	<ul style="list-style-type: none"> <li>- Interpretation</li> <li>- Diagnosis</li> <li>- Questioning</li> <li>- Information</li> </ul>	<ul style="list-style-type: none"> <li>- Challenge</li> <li>- Confrontation</li> <li>- Information</li> </ul>	<ul style="list-style-type: none"> <li>- Edification (faith)</li> <li>- Empowerment</li> </ul>



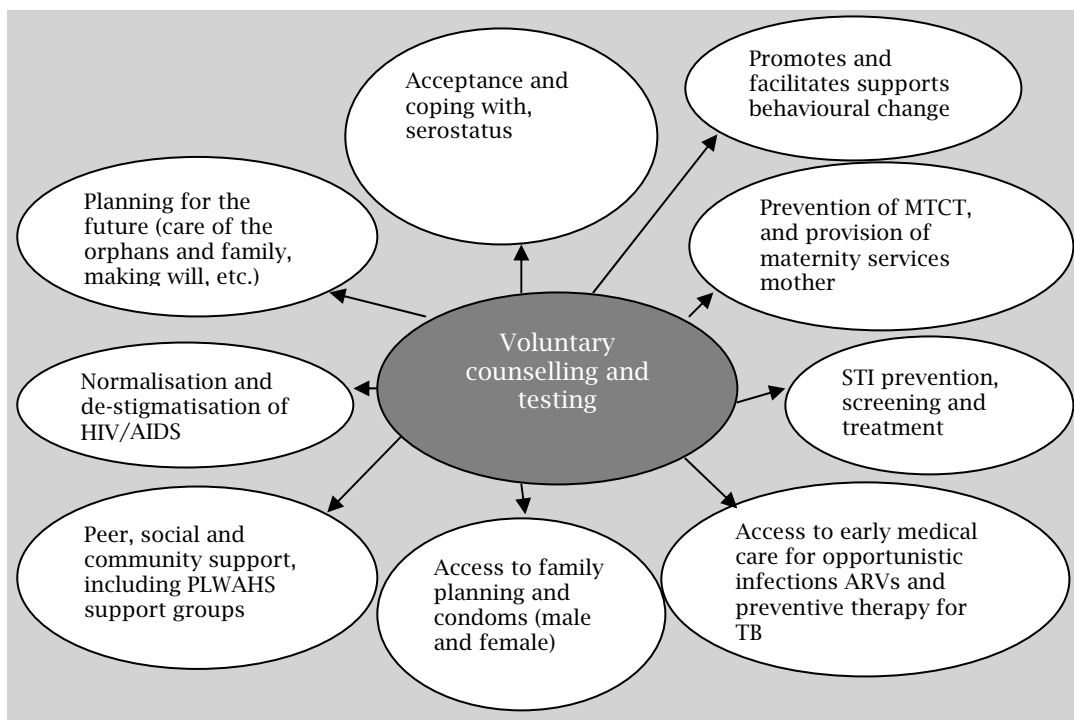
The different stages in the stage model do not mean that each stage is demarcated clearly from the other, without overlapping. There are always cases of overlapping between stages during the counselling conversation. There is no way for a human being to be compartmentalised, which may be the wrong impression conveyed by the stages. Also, one stage does not automatically lead to the next, as the stages are interwoven. They are just a compass indicating the direction counselling should go. In African pastoral counselling, where counselling does not adopt the Western professional approach, it is valuable to know the right questions to ask and to be competent in story/narrative analysis and worldview, so that you can cope with possible roadblocks. After pastoral diagnosis, in our case of the person living with HIV/AIDS, I should proceed to counselling in Africa. But what is HIV/AIDS counselling and what does it entail?

### **5.3.4 HIV/AIDS counselling in Africa**

#### *5.3.4.1 Pre- and post-HIV test counselling*

HIV/AIDS counselling takes place in two categories, i.e. pre- and post-HIV test counselling, which is usually through voluntary counselling and testing. The purpose of pre-HIV test counselling is to find out why individuals want to be tested, what the nature and extent of their previous high-risk behaviour is, and what are the steps that need to be taken to prevent them from becoming infected and transmitting HIV infection (Jackson 2002:179-199; Van Dyk 2001:237-253). The pre-HIV test counselling is extremely important, since it is a golden opportunity to educate people about HIV/AIDS and safe sex as some may decide not to come and collect their results. Below is a summary of opportunities resulting from pre- and post-HIV voluntary counselling.

## Summary of voluntary counselling and testing as an entry point for HIV prevention and care



The same person who does the pre-test counselling should do the post-HIV test counselling, since it is a continuation of the pre-HIV test counselling and a relationship has already been built. If the person is negative, the possibility should be pointed out that the person could be in the window period. The person should be educated in safe sexual practices. An “inclusive test” does not indicate whether the person is positive or negative, either because the test will be cross-reacting with a non-HIV protein, or because there has been insufficient time for full sero-conversion to indicate HIV. In such a case, other tests can be done or the test repeated in two or three weeks. However, the biggest challenge is when the person is HIV positive, which would lead to AIDS.

HIV-infected people experience psychological, spiritual and socio-economic needs resulting in fear, loss, grief, guilt, denial, anger, anxiety, low self-esteem, depression, suicidal behaviour or thoughts, obsessive conditions, spiritual concerns and socio-economic issues. A further complexity of HIV/AIDS is that it adversely affects significant others, who could be family members and friends (the affected). These people should also be counselled. The significant others should be empowered to offer a support base and have referral skills. Pastoral care through *koinonia* is pivotal in offering this support or cushion to

the infected person and affected family members.<sup>8</sup> The post-test counselling creates a challenge and an opportunity for the church to accept and care for the person in the *koinonia* family.

In summary, HIV pre-test counselling seeks to find why individuals want to be tested, the nature and extent of their previous high-risk behaviour, and steps that need to be taken to prevent them from becoming infected or transmitting the infection. It is an important opportunity to educate people about HIV/AIDS, since some of them may not come to collect their results. HIV post-test counselling is a further opportunity to educate people on safe sex if the person is negative, but if positive, it is an important opportunity to put him/her in a support system, which in our case is the congregation (*koinonia*) for continual care and counselling. But how does HIV/AIDS pastoral counselling proceed?

#### 5.3.4.2 HIV/AIDS pastoral counselling

“Pastoral care” and “pastoral counselling” are phrases that are often used interchangeably, though they can be differentiated. In speaking of pastoral care, pastoral counselling is implied or assumed. One cannot be a pastoral caregiver and not be a pastoral counsellor. Theologically, these activities are referred to as *cura animarum*,<sup>9</sup> which describes “a very special process of caring: caring for human life because it is created by God and belongs to God” (Louw 1998:22-23). However, *cura animarum* should not be mistakenly perceived as only the pastor’s responsibility. This understanding of *cura animarum* overlooks the central role of faith community (*koinonia*).

In Chapter 4 the role of the faith community (*koinonia*) in providing mutual care through systems approach was emphasised. The central role of *koinonia* care is in line with Crabb (1979), Obeng (2000:7) and Louw’s (1998:13-17) observation that pastoral care is shifting away from the unilateral professional approach to the mutual care of believers: *koinonia*. Thus pastoral care and counselling are the responsibility of all believers. Hence for pastoral care to incorporate the notion of *koinonia*, it may be necessary to precede the terms “care” and “counselling” with the word “Christian”, so that it becomes “Christian counselling”. This emphasises the central role of *koinonia* in order for people not to have misconceptions by associating pastoral care with “pastors” only. Besides, when one speaks of “pastoral,” it implies pastoral from the perspective of Christian theology. Louw (1998:260) emphasises that:

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<sup>8</sup> Some HIV-positive people may prefer disclosing to the pastor or church people, but not to their families. An example is an incident shared to this researcher by a third-year theological student at George Whitefield College in Muizenberg. The HIV-positive person chose only to disclose to him as the assistant pastor.

<sup>9</sup> *Cura animarum* is the classical formulation for pastoral work.

*Although it is very difficult, and even dangerous, to distinguish between the pastoral roles of believers and the clergy, it is helpful to bear in mind that pastoral counselling does not mean a distinction in character between counselling offered by clergy and the pastoral care offered by believers. It is more a functional distinction, with the accent being placed on the uniqueness of the relationship between pastor - parishioner within the context of the *communio sanctorum*. **The principles, which undergird pastoral counselling, are applicable to all other forms of Christian counselling** [my emphasis in bold].*

This understanding of pastoral counselling should be the basis for a congregational ministry or home-based pastoral care, especially considering the church family systems approach as argued in Chapter 4. The entire community of faith should be involved in caring and counselling, each at his/her own level.

However, I should note that “counselling” is a word that may have slightly different interpretations for different people in different contexts (e.g. in psychological counselling, Christian counselling, and AIDS counselling) and in Africa. In *Perspectives on Counselling Theories*, Louis Shilling (1984:2) comments, “Counselling is a word that everyone understands; but no two people understand it in quite the same way. Even within the same profession, there is agreement but not unanimity”. Nevertheless, the supposed differences should in no way compel one to perceive the differences as a deterrent to understanding the core of counselling. The only big difference is evident in a Christian approach and a psychological approach to counselling, because they operate from different presuppositions. But still, they share many aspects.

To have clarity on the working and understanding of counselling, in addition to what I mentioned earlier, let us consider four representative voices that approach the subject from different perspectives.

- ≈ First, Lartey: Having worked in West Africa for many years, he attempts to reflect an African flavour in his writing. He says, “Counselling is the skilled and principled use of relationship to facilitate self-knowledge, emotional acceptance and growth, and optimal development of personal resources” (Lartey 1997:56).
- ≈ Second, Miller and Jackson: These authors approach the subject more from a psychological perspective. They respond as follows to the question, “What is counselling?”

*Counselling is a special kind of a helping relationship. It follows from an agreement between two people to enter into a relationship whereby one (counsellor) applies special skills to assist the other in the resolution of a personal or interpersonal problem (Miller and Jackson 1985:2).*

- ~ Third, is Louw: He approaches counselling from a bipolar Reformed approach and explains that:

*The term counselling refers to a helping relationship in which, through a series of structured contacts, the counsellor seeks to alleviate distress and to promote growth in the person seeking help. Counselling could be defined as structured talk therapy within a helping relationship of mutual trust regarding the being qualities of a parishioner (Louw 1998:260).*

- ~ Fourth, Clinebell: Focusing precisely on pastoral care and counselling, Clinebell, writing from an American perspective, states:

*Pastoral care and counselling involve the utilisation by persons in ministry of one to one or small group relationships to enable healing empowerment and growth to take place within individuals and their relationships (Clinebell 1984:25-27).*

Word	African	Psychology	Bipolar Reformed	American
	Lartey	Miller & Jackson	Louw	Clinebell
<b>Relationship</b>	The skilled and principled use of <b>relationship</b>	Counselling is a special kind of a helping <b>relationship</b> .	The term counselling refers to a helping <b>relationship</b>	Pastoral care and counselling involve the utilisation by persons in ministry of one-to-one or small group <b>relationships</b>
<b>Facilitation</b>	To <b>facilitate</b>	It follows from an agreement between two people to enter into a relationship whereby one (counsellor) applies special skills <b>to assist</b> the other in the resolution of a personal or interpersonal <b>relationship</b>	Through a series of <b>structured contacts</b> , the counsellor seeks to alleviate distress	To <b>enable</b> healing <b>empowerment</b>
<b>Growth</b>	Self-knowledge, emotional acceptance and <b>growth</b> , and <b>optimal development</b> of personal resources	<i>Implied in facilitation</i>	To <b>promote growth</b> in the person seeking help	<b>Growth</b> to take place within individuals and their relationships

These representative voices on counselling, despite their different approaches, explicitly or implicitly underline three key words, i.e. relationship, facilitation and growth. Thus counselling is about a *relationship* (counsellor-client), where the counsellor *facilitates* the client's *growth*. The relationship is between the pastoral caregiver who can be the pastor or congregation member committed to the task, and the HIV/AIDS-affected person or people in our case. The affected people to be counselled are the people living with HIV/AIDS (the infected person), significant others i.e. the family members (directly or indirectly affected people), and the children. A relationship with these people is necessary for them to open up. Facilitation is about making the environment favourable to positive change. Rogers's client/person-centred approach utilises this notion. Growth refers to adjusting to living positively with the HIV/AIDS status. It is important, however, to mention that counselling should be holistic. The person should be viewed as a whole and not as compartments, e.g. emotions, relationship, spiritual, etc. And pastoral counselling always aims at spiritual growth.

Egan (1998) underlining the same counselling thoughts as above, added the purpose of counselling as helping the person to manage his/her problems more effectively and develop unused or underused opportunities to cope more fully, and to help and empower the person to become a more effective self-helper in the future. However, while these authors' description of counselling is valuable, we should also consider counselling from an African perspective, which Lartey – though attempting to write from an African perspective – fails to capture.

Berinyuu (1988:93-98), in *Pastoral Care to the Sick in Africa*, focusing on African counselling, equates the role of pastoral counsellor to that of the African diviner. He argues that the task of the diviner is to scrutinise the past in order to identify the spiritual and human agents responsible for the human and communal misfortune. The diviner is a story listener and interpreter. Therefore, counselling is listening to and interpreting people's stories. People seek counselling because they need someone to listen to their story. And the story is tangled, it involves themes, plots and counter plots. The story itself is an interpretation of experience and one seeks a counsellor because the interpretation has become painful. Berinyuu, therefore, adds,

*The stories that Africans bring to the diviner (i.e. counsellor) are everyday stories. They are also expressed in everyday language. The stories normally centre on relationships affecting one's clan. The symbols and signs used to express these relationships come also from everyday life situations of the cultural milieu (1988:96).*

The counsellor in Africa, therefore, should be able to listen to and interpret stories.<sup>10</sup>

Mwaura (2000:83), in his article *Healing as a Pastoral Concern*, also focuses on counselling in Africa. He, like Berinyuu, underlines the parallels between pastoral counsellors and diviners. The diviners, he states, “are able to give a diagnosis and heal the sickness” (2000:83). He further emphasises the crucial role of holistic counselling as pivotal to healing in Africa in whatever situation. Therefore, with HIV/AIDS counselling the counsellor (diviner) should listen to the victim’s story and interpret it within a holistic perspective.

Berinyuu and Mwaura, however, fall short by not mentioning that African counselling often takes the form of advice counselling. Usually when African people seek counselling, they are looking for wisdom and direction. Kiriswa (2002:25) in *Pastoral Counselling in Africa: An integrated approach* also noted this counselling approach in Africa. He argues that in Africa a counsellor is viewed as an “advisor”. A counsellor or advisor utilises insights and values drawn from the rich African wisdom and cultural heritage as informed by African worldview or philosophy of life. These involve religious beliefs, social norms, concept of sickness, and communitarian approaches to life (Kiriswa 2002:25). The elders of society therefore – because they are perceived as the most informed on social and life issues – are the ones who are usually consulted for counsel, which is given as advice with little or no room for alternatives. Kiriswa (2002:30) clarifies that:

*In African tradition, counsellors were people of high integrity maturity, experience and natural wisdom. Traditional counselling placed too much emphasis on the age of the counsellor. As such, children did not qualify to be counsellors because in most African societies age was a sign of experience, wisdom and maturity. A special place was given to elders, specialists like artisans, leaders, rainmakers, medicine men and diviners [my emphasis].*

This therefore means that when one goes for counselling, one normally expects to be given advice, which differs slightly from facilitation in the Western approach. In addition to the advice approach to counselling, Kiriswa (2002:26) rightly argues that counselling in Africa should be community centred and include the extended family.

The importance of the community centred approach to counselling cannot be emphasised enough in HIV/AIDS counselling in Africa. The people living with HIV/AIDS are in many cases stigmatised and discriminated against. And during the severe illness stage (full-blown AIDS) they opt to go home (usually rural) to

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<sup>10</sup> For detailed discussion on stories see pastoral assessment - narrative approach in the following sections.

their relatives' *azofela ekhaya* (lit. die at home) (Ncube 2003). In such a situation the extended family and community perform the caring and counselling role. The extended family and community in most, if not all, cases are ready to accept and embrace the person. This therefore means HIV/AIDS counselling should incorporate a community dimension in Africa. Coping with HIV/AIDS entails a community that accepts and buffers the affected person(s). But what then, precisely, is HIV/AIDS counselling? What does it entail? Can pastoral counselling provide such a community base as in African communities?

Van Dyk (2001:201), referring to HIV/AIDS counselling, states:

*The counsellor cannot change the adversity inherent in the client's status or events that caused it. The counsellor's sphere of influence is defined by the aftermath of the disclosure of the HIV-positive status - how the client reacts, how significant others react, and how these reactions might impact upon symptom development, the course of the disease and the quality of the client's life. The aim of counselling the HIV-infected individual is therefore to focus on life beyond infection and not to dwell unnecessarily on the constraints of the disease. The counsellor's role is to facilitate the client's quality of life by helping him or her to manage problems, to effect life-enhancing changes and to cope with the kinds of problems that will arise in the future.*

The goal of Van Dyk's counselling approach of enhancing changes in life is sound, but I ask: do counsellors have the ability to enhance such changes, since conversation achieves therapy? I strongly hypothesise that enhancing hopefulness, i.e. quality of life beyond infection, requires a more holistic and assuring approach than Rogerian client-centeredness. Although Van Dyk has a valuable goal, can this client-centeredness be the most appropriate therapy to achieve the goal in HIV/AIDS?

The World Council of Churches' mission and evangelism guide to HIV/AIDS pastoral counselling (Online) states:

*People living and dying with AIDS have spiritual and emotional as well as medical needs. They ask questions related to God and the soul, life and death, condemnation and forgiveness, eternity and transcendence, forgiveness and salvation. They are looking for pastoral counselling, consolation and acceptance. In some places, pastors and churches are the nearest or only resources available in times of crisis and need.*

The World Council of Churches' observation about HIV/AIDS counselling is crucial. HIV/AIDS brings anxiety and despair, and issues of soulfulness, life, death, condemnation and forgiveness, eternity and salvation to the surface.



Furthermore, because of stigmatisation and discrimination, the individual longs for consolation and acceptance. Therefore to address the situation we hypothesise that pastoral/Christian therapy (Counselling) is a more holistic and reassuring approach.

The person living with HIV/AIDS longs for soulfulness, life, death, forgiveness, salvation, eternity, consolation and acceptance that is provided by a caring faith community (*koinonia*) which graciously accepts and identifies with the person. Christian life, Wislon *et al.* (1996:195) state, is life in community, and the search for better community is central to the network of Christian ministry. Louw (2005:10), in *Mechanics of the Human Soul*, therefore adds that soulfulness and coping in crisis results from the quality of networking and systemic relationships, which can be provided by *koinonia* as argued in Chapter 4. This argument can rightly be advanced for and by people living with HIV/AIDS regarding their existential crisis. Thus:

*People cannot cope with many crises in life because they do not understand the mechanics of the processes of networking and relational interactions (the happenstances of life). When they try to utilise the so-called potentials of their soul, they become more confused due to the fact that life itself starts to become intolerable (Louw 2005:10).*

Louw's argument dismisses the psychological argument of sole dependency on inner potentials, especially in HIV/AIDS counselling and encourages communal (relationships and network) healing, which underlines the *koinonia* healing function. In this sense, therefore, the communal approach that includes the extended family in Africa, as argued by Kiriswa, should be incorporated in HIV/AIDS counselling.

The World Council of Churches reasoning that churches are in proximity to people living with HIV/AIDS in African communities blends well with the *koinonia* approach, which brings healing. In addition, the church has the theological grounds and motivation to provide the much needed pastoral care and counselling (as argued in Chapter 4). Pastoral/Christian therapy (or counselling) communicates God's identification with humanity in suffering (including HIV/AIDS) through Christ, which is also an arguably more appropriate solution for the person living with HIV/AIDS person than the psychological person-centred approach. Christian hope in Christ may possibly help the person to deal constructively and meaningfully with their HIV/AIDS condition. The centrality of pastoral/Christian therapy to people such as those with HIV/AIDS is aptly summed by Louw (1998:7-8):

*No other discipline is well equipped to deal with the issue of forgiveness and the fear of death as pastoral therapy. In fact, the uniqueness of pastoral therapy resides in its ability to offer hope, which both*

*transcends the present situation and anticipates the ideal. Even more, it can transform human existence so that victory over sin and death can become reality, which imparts meaning to life [my emphasis] (Louw 1998:7-8).*

In summary, pastoral care (*cura animarum*), as has been mentioned, basically means caring for people. The caring is not only the responsibility of the pastor but of the whole faith community (*koinonia*). The *koinonia* approach, much as the African communal approach that utilises human networks and systemic relationships, should be incorporated in HIV/AIDS counselling. Thus HIV/AIDS counselling in Africa, apart from the other premises described above (relationship, facilitation and growth), should be distinguished as counselling that utilises the notion of community derived from the extended family and community. And the faith community (*koinonia*) should provide the caring function. A *koinonia* approach encourages acceptance and identification with the person living with HIV/AIDS thereby bringing healing. It dispels stigmatisation and discrimination. Furthermore, as the person living with HIV/AIDS experiences losses and impending death, pastoral care can help the person to deal constructively and meaningfully with the situation through God's identification with the suffering (HIV/AIDS) through Christ. Thus God is beside the person in his situation as evidenced through *koinonia* members who walk the journey with the person (embodying love and gospel).

My task in this section was to describe counselling, with a special focus on pastoral counselling in Africa. But regarding our subject, i.e. HIV/AIDS pastoral counselling within the African context, I pose the following pertinent questions: what is African therapy and how is it achieved? How does a systems (*koinonia*) approach, which is the basis of our argument, provide a horizon in which pastoral and African therapies merge for effective HIV/AIDS care and counselling?

#### *5.3.4.3 HIV/AIDS counselling: contextuality (poverty) and the African scenario*

##### **African counselling - community and extended family healing function**

African counselling or therapy, Berinyuu (1989) states, is counselling where the community and the extended family corporately seek a solution to a crisis. Life in traditional Africa was communal and many stress-generating situations were resolved before they overwhelmed an individual. Everything revolved around the community where human relationships, conduct and moral integrity were constantly moulded, checked and controlled. Where there was misunderstandings or broken relationships that could lead to distress or sickness, the community determined the process of guidance and counselling,

which was often public as opposed to private. The community became the counsellor, healer and advisor. The African extended family system reinforced solidarity and co-responsibility among all the members. Emphasis was laid on interpersonal relationships and moral support from all the members of the family clan (Kiriswa 2002:26).

Furthermore, apart from the community-centeredness and extended family counselling, preventive counselling was also common. Through initiation ceremonies young men and women were taught community expectations to prevent them from breaking community norms and values that would bring misfortune on them and the community.

The cause of sickness in Africa is perceived to be through offending either God, ancestors, a broken a taboo or custom, which is believed to be a reason for punishment by God or the ancestors. At times sickness is attributed to an offence against the gods, spirits of the ancestors and the living dead, and other mysterious forces. At times it could be witchcraft, sorcery or enemies with magical powers to cast misfortunes (Berinyuu 1988; Kasambala 2004; Kiriswa 2002; Mwaura 2000; etc.).

In cases of sickness, therefore, treatment was provided through ritual purification, exorcism or sacrifices. Right relationships had to be maintained, starting with the nuclear family, to the extended family, clan, tribe, gods, spirits, etc. Counselling was sought from the respective elders, who then advised the individual or family on the appropriate rites, exorcism, sacrifice, purifications and confessions to restore the balance. Kiriswa (2002:30) commented that it is believed that without a ritual performance the person would not experience psychological healing. A ritual confirmed that the person received the necessary attention and healing.

African counselling, Kiriswa (2002) added, was a type of hospitality measured by the kindness, warmth and friendship of the counsellor, which parallels warmth in psychotherapy. Sickness by any member in the community was never taken for granted. The health of a person was the responsibility of the whole community. The well-being of one meant the well-being of all; when they celebrated, they did it together, and when death occurred, they grieved together. A healing ritual as a balance-restoring exercise signified support, concern, love and a sense of belonging. Therefore to avoid things that may harm (destabilise) the system (balance), someone experienced and elderly should be consulted for counselling (advice) in order to preserve the community. That is why African traditional counselling was supposed to be done by specialised and experienced elders and not young people.

Rituals that were performed to restore the balance were done in a communal context. And through this the counselee regained self-acceptance and a sense of belonging by realising that he/she is not alone on the journey of the

challenges of life, and that there are people to support, encourage and confide in when trouble arises that affects healing.

The contribution of African counselling regarding our argument for a systems approach, especially in HIV/AIDS counselling, cannot be exaggerated. The support and “being there for each other” formula should be translated to *koinonia* care (mutual care) to encourage support of one another. Reconciliation fostered through community rituals is also invaluable in inculcating acceptance of one another despite their status, which dispels stigmatisation and discrimination of people living with HIV/AIDS. Grace will be extended to one another despite their circumstances. However, the crucial African and pastoral counselling question that we should pose is: how can a pastoral counsellor integrate African counselling (therapy) and pastoral counselling (therapy)? How do the pastoral metaphors that foster healing link African therapy with the *koinonia* systems approach?

### **Pastoral counselling within an African setting – integrating African healing**

Pastoral healing, as mentioned, is about salvation. Healing theologically refers to the event of being transformed from a condition of death to a condition of life through God’s unconditional grace in Christ. This state of new being entails a shift in thinking, which determines one’s response in HIV/AIDS. The thinking should be influenced through Scripture, thus embracing a biblical view of sickness and suffering. In this sense, therefore, a person suffering from full-blown AIDS who is bedridden can be healthier than a physically fit person: “Though outwardly we are wasting away, yet inwardly we are being renewed day by day” (2 Cor. 4:16).

Sickness and suffering, especially HIV/AIDS, if one is innocently infected triggers the “why?” question. In *Meaning in Suffering*, Louw (2000:21) states that:

*In why? the concentrated grief of a finite is expressed to God: it is distressed cry for help and consolation. At the same time, the why? is an attempt to understand the enigma of suffering. For the unbeliever, why? can be an expression of total despair about the future that can eventually lead to a rejection of God. For the believer, why? is an indication of the struggle with God’s justice in the midst of an experience of affliction, grief and guilt. It is an attempt to find a reasonable cause and solution” (Louw 2000:21).*

However, when an African goes through sickness and suffering (e.g. HIV/AIDS), the “why?” question is preceded by “who?” An African wants to know “who” caused it (i.e. maybe it is the witch or ancestor) and then “why” it was done (i.e. possibly the ancestors are angry with the person). Ncube (2003:98), in referring

to the Zulu context, also alludes to this African dynamic. He states that *ukubhula* (divination) offers an explanation of the cause of sickness by the diviner and *ukwelashwa* (finding the cause of sickness and appropriate treatment) gives hope of recovery or prolonged time. The laws of cause and effect concern the “who” of causation for Africans rather than the “what” of Westerners. *Ukubhula* addresses the who-ness of things around contamination by the virus. And in diagnosing the cause of the disease or misfortune, the diviner always discovers the cause either in witchcraft and sorcery and/or in the anger of the spirits.

The elders in Africa, as highlighted earlier, are the ones who advise an individual or family on the rightful people (diviners or healers) who are able to address the situation. In this sense, therefore, the elders’ advice is taken seriously and one should embrace it. Refusal to take the advice creates tension with the community. The person would be considered to be deviant. However, it should not be the case in the context of suffering caused by HIV/AIDS. It is known that HIV/AIDS is caused by a virus, hence any divination only brings conflict and enmity among family members.

Thus when an African asks the why? question, he or she receives an instant answer from a witchdoctor or diviner – which is slightly different from Louw’s point. Berinyuu (1989:63), in *Towards Theory and Practice of Pastoral Counselling in Africa*, sums up African therapy as follows:

*Your sickness, misfortune, or condition can be traced to either an inappropriate action by one member of the family or a conflict that existed among members of the family who may be dead. The **purpose of the therapy is to say to the offender, you have done wrong or wrong was done by someone else, we have accepted responsibility, confessed the guilt/shame/damage by an appropriate ritual.** If it was a past conflict, descendants of the parties who gave rise to the conflict do the confession on behalf of the dead [my emphasis].*

Within this African framework therefore, for a Christian therapy to apply in Africa, we hypothesise that a Christian/biblical worldview or understanding should be in place. This entails what this researcher could call “culture or worldview *metanoia*” – with sensitive inculturation, which directly relates to our discussion. Thus Xolile Keteyi (1998:38), referring to inculturation, stated:

*There are two sides to inculturation. It is both the imparting of faith (its insertion in a new culture) and its reception (the appropriation of the gospel through culture). This means that in the process of inculturation there are two processes involved. On the one hand, inculturation is a form of evangelisation that is sensitive to culture. On the other hand, it is a culturally based process of conversion [metanoia - VM]. It is equally*

*an acknowledgement by other cultures that there is no culture that is a totally adequate human expression or a single approach to the kingdom of God (Keteyi 1998:38) - [my emphasis].*

In this regard the African worldview that answers the why? question (cause and effect) should be shifted (*metanoia*) to biblical thinking that contends with God's transcendence and human fallibility and limitation. Wannenburg (2003:10 sermon 1), in a sermon series entitled *When Life Hits the Fan: Rock Bottom* on the book of Job, made an important comment. He says that we will not always know exactly why we suffer. Sometimes we do, such as when we fail an examination because we never attended classes or studied a book. Sometimes we suffer for our sins. At other times, we have done nothing wrong to deserve suffering. Therefore the African notion that every sickness is linked to a supernatural cause should be seriously challenged. This, however, does not negate or deny the influence of evil powers, because to deny their influences would be denying Scripture. The point being made is that such an inquiry into the "who-ness or why-ness" is forbidden in Scripture (Lev 19:26; Eze 13:20; Rev 21:8, 22:15) and it creates enmity among people, especially close relatives. A Christian therefore, as mentioned above, should embrace the biblical view of suffering and sickness.

Therefore, we should ask the following question: how can one correctly refer or think of God in suffering or HIV/AIDS situation in Africa? The appropriate way, this researcher argues, to think of God in suffering is to focus on His Son Jesus Christ. By focusing on Jesus Christ, one would view God in terms of His identification with human needs and suffering (*pathos*).<sup>11</sup> One should not fear the threat of some spiritual influences or any other supernatural forces.

But within an African context, where the person views himself to be part of a system that exerts an influence on him/her,<sup>12</sup> how is it possible for one to break from the system and then have the assurance that God protects him/her? How could one refuse community advice, especially from the elders who are perceived to be the rightful people to advise an individual on the right ritual or diviner and still get healed? Is it possible to think of God concretely, so that the people who are in tension with their traditional family community still get community healing?

Salvation and healing in Africa, Okoye (2005) argues, is not about the future and individualistic, as the missionaries put it, but about the present, communal

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<sup>11</sup> Apart from God's identification with the suffering (HIV/AIDS), the church or congregation members (*koinonia*) should also, through empathy, identify with HIV/AIDS-infected people. Identification with them as part of the congregation/church system dispels stigmatisation and fear of rejection (see Chapter 4 on church family systems function).

<sup>12</sup> See section on pastoral assessment for the discussion on the African family influence on pastoral healing.

and holistic. It is about the well-being and possession of life in its fullest potency. When one is against the family and community ancestors through rebellion and deviance, one needs daily salvation derived from the spiritual world. Therefore in such a case the sufficiency and omnipresence of God should be concretely communicated and embodied in order to bring healing.

Thus, the task of pastoral care and counselling is to link the abstract God to existential situations. Pastoral theology seeks a biblical metaphor which can be used as a figure of speech in the theological vocabulary to present, comprehensibly and meaningfully, the unknown (revelation) in terms of the known (creation). Metaphorical theology is an attempt to take the meaning dimension of God-languages and contexts seriously. Its objective is to understand the process of naming God in terms of real-life issues. Metaphorical theology enhances the dynamic interplay between God and existential events (Louw 2000:49).

The pastoral counsellor in Africa, therefore, should identify metaphors in Scripture that depict God in terms of his identification with human sickness and suffering. These metaphors should not only be communicated but also embodied. The following metaphors therefore could be identified: Shepherd (solicitous care), Suffering Servant (pathetic identification), Wisdom or Wise fool (presence of God through paradox), and Paraklesis (guiding, encouraging, empowering, consoling, sustaining, and reconciliation) (Capps 1984:66-69; Louw 1998:39-54).

*Shepherd:* God's shepherding of his people is clearly linked to God's covenantal care of Israel (Psalm 23; Ezek. 34). This care is also expressed in the charity and love revealed by Jesus' ministry and fulfilled in his sacrificial death (John 10:11; Mathew 26:31). Important about the shepherd, however, both in the Old Testament and New Testament, is that he shepherds a flock (group) not a single sheep in isolation. Yahweh was the shepherd of the Israelite community and Jesus called himself a shepherd of the flock (Mat. 26:31). In Luke 15:1-7 Jesus refers to himself as a shepherd who goes out to look for one sheep out of a hundred if it gets lost, until he recovers it and puts it together with the rest (the other ninety-nine).

To link the shepherding nature of Jesus Christ to *koinonia* (system) care and counselling, it may not be far fetched to say that Jesus the good Shepherd intends his flock (church - believers) to be always together and interacting with one another. Love one another and through this people will know that you are my disciples, to paraphrase Jn 13:34-35. Thus to experience the love and care of God the good Shepherd is to share it with others. The shepherd metaphor therefore in this sense does not only communicate God's care to people, but challenges Christians to care for and love one another. This notion of community further links well with African communality. The implication

therefore for HIV/AIDS care counselling is that believers should extend Christ's love and care that they have experienced to the affected people.

*Suffering Servant:* The servant metaphor communicates in a very special sense the way in which God identifies with human suffering (Isaiah 52:13-53:12). God's identification with human suffering is also evident in the work of Jesus Christ (Matthew 12:18; Acts 4:27) and how he applied Isaiah to himself (Luke 22:37). The suffering servant implies that he suffers on behalf of the people (Mark 14:24). Jesus, by humbling himself to become man, assumed the role of a servant. Thus the servant (Jesus) willingly sacrificed and identified with human sickness, suffering and distress. Jesus as a suffering servant does not remove our suffering, but it becomes more painful as we are compelled to face our own suffering. But we face it with the crucial difference that the Crucified one can share our own suffering and sickness, and can generate hope and a new vision.

The church (system) as a community that belongs to Christ does not stand aloof, but identifies and accepts the individual(s). Fellow believers share the pain with him/her (them). And within the African context of poverty and HIV/AIDS, it means the sick may not need to know who caused the sickness and why he/she caused it or under what circumstances did the person get HIV. Christ and my fellow believers are there for me/us and they share the pain and sickness with me/us.

*Wisdom or Wise Fool:* Wisdom lies in love for and awe of God (Proverbs 9:10). The ability to discern the essence of life begins with knowledge about God. However, wisdom is concerned with being human within the world. It guides behaviour. In the New Testament wisdom is related to morality and the development of virtue (James 3:13-18; Galatians 5:19-23). But another characteristic of wisdom is contrasts and paradoxes (1 Cor. 1:18-25). Christ is the wisdom, but the world does not know him. They think they are wise, but they are foolish. In Africa relatives and friends may suggest consultation with diviners in times of crisis. But a wise fool (wisdom) could answer back and say all things are under the foot of Christ (Col. 1:15ff). A wise fool in times of sickness and suffering may say, like the Apostle Paul, "Where, O death, is your victory? Where, O death is your sting?" (1 Cor. 15:55). Thus where is your power O sickness or HIV/AIDS, since Christ conquered all powers? But to have this stance in life despite your status requires strength and *koinonia* support.

*Paraklesis:* Paraklesis entails guiding, encouraging, empowering, consoling, sustaining and reconciliation by God. And in the context of *koinonia* each member, in a sense, provides a parakletic function to the other. They encourage one another in their situations. Because Jesus does not want us to be worried and concerned like orphans; he sends the *parakletos* from the Father (Jn 15:26). On the other hand, the Father sends the *parakletos* at the request of Jesus (Jn 14:16,26). And Jesus himself is a *parakletos* who is distinct from the



other *parakletos* whom the Father sends in his name. Therefore the *paraklesis* metaphor combines all the other metaphors in depicting God's active involvement and care in people's situations. This involvement, if embodied by believers, provides tremendous healing to anxious and despairing people living with HIV/AIDS.

These metaphors: Shepherd, Suffering Servant, Wisdom or Wise Fool, and Paraklesis, depict God's involvement in people's suffering and the HIV/AIDS situation, which the church should imitate. Pastoral counsellors (church - *koinonia*) should not only concentrate on inculcating faith in God, who identifies with his people as evidenced in his Son, but should also embody these metaphors. These metaphors perceived in communal terms as in the African context, challenge and encourage mutual care and interdependence of believers. They foster a God who is a Friend, Partner and Companion for life through day-to-day translation of God-language to the practical HIV/AIDS situation. In this sense, therefore, someone in Africa who may experiences tension with the traditional community may find a "hidden nest" among fellow believers. They encourage him and are his companions, thereby replacing the healing role of the traditional community and extended family.

Above, pastoral therapy - also termed salvation therapy, hope therapy and promissiotherapy - has been discussed. It is about God's faithfulness, his promises and the Gospel's offer of redemption. Perspective (salvation), ontic condition (faith) and orientation to the future (hope) are three similar issues responsible for giving meaning in life. The objective of pastoral therapy is spiritual maturity, faith development and growth; and they are offered by the *koinonia*. Within the African context, therapy involves the community and extended family. It entails rituals, sacrifices and exorcism, etc. to restore the balance. It has also been argued that in the event of one attempting to embrace pastoral healing, tension with traditional forms may arise. The tension may result in the person being considered a deviant in the community and hence sanctions are applied. In such a scenario one should think of God as a shepherd that does not forsake his sheep (Shepherd), identifies with him in his/her situation (Suffering Servant), one who challenges the unbiblical norms (Wise Fool), and as one who is always there to encourage and console the person (*paraklesis*). The community of faith (*koinonia*) should embody these metaphors in order to be effective in action and not view them merely as abstractions.

Pastoral counselling aims at spiritual maturity, faith development and growth. The counsellor should be able to assess these issues within the African context in order to offer appropriate counsel. Thus we should ask: what issues should a pastoral counsellor in Africa concentrate?

#### *5.3.4.4 Assessment in HIV/AIDS counselling: a model for Africa*

In Africa the counsellor (i.e. Pastor/Christian counsellor) should assume the role of a diviner (Berinyuu 1988; Mwaura 2000). The counsellor (diviner) must listen to people's stories and interpret them. Story telling and listening are crucial in African counselling. The stories are contained in proverbs, idioms, symbols, etc. that the counsellor (diviner) should be able to interpret (Kasambala 2004). The counsellor should be able to listen and try to "fix the puzzle" by probing inconsistencies in the story. McKeever's narrative model focuses on stories of life to attain insight into parental education and religious experiences. Louw also views stories as critical in analysing the counselee's God images. In Africa, especially among the poor, stories are valuable because not much writing is done, as the people are generally illiterate. Therefore the counsellor should have an accurate knowledge and understanding of analysing the African view of suffering in order to offer effective HIV/AIDS care and counselling.

However, the value of the story/narrative approach in Africa is often over-emphasised, as evidenced in Berinyuu's and Kasambala's work among many others. Over-emphasising stories has the danger of elevating them to become complete documents or texts that can easily be read, analysed and interpreted, and then intervene. This, however, may appear a reductionist understanding of story/narratives, but the argument is that African writers tend to amplify the value of stories as an attempt to come up with a truly African counselling approach. These writers overlook the centrality of the African worldview in diagnosis (though, of course, stories are analysed based on worldview!).

To partly illustrate the argument let us consider the story below:

Peter grew up in a village. His parents hold a strong view that he should not marry people from a certain tribe. When Peter went to college, he met Jane from that tribe and fell in love with her. Despite his father's disapproval, as a Christian (new person in Christ) he married Jane. However, when five years elapsed without conception, they began to have conflicts. Jane puts pressure on Peter to check with his father about the possible cause of their problem.

If the above story is narrated to a pastor, on the surface it may not mean much. It would seem just like a misconception issue. But to understand it this way would be to pluck it out of the African context and worldview. It may require one to understand the worldview of these people. The issues in the story that the pastor may need to know in order to counsel this couple could be:

- ☞ The relationship of Peter and his family (father), which Jane might think is the cause of the problem;

- ∞ Directly connected/related to the issue of relationship is the belief of how the situation can be addressed (may be a ritual or sacrifice to restore the relationship);
- ∞ The counsellor may also need to know their worldview regarding marriage and children.

As partly illustrated in the above story, it should be underlined that an African pastoral counsellor should listen to stories with the intention to get “clues or sign-posts” for avenues to probe (basing on knowledge of the worldview), which then means questioning (probing) is an important technique in African diagnosis also, and not just story analysis. A good working knowledge of the African worldview is vital for the counsellor to be able to read behind the story. Tebogo Mazibuko (July 2004), in her presentation on *Ubuntu*, rightly observed that African beliefs and practices are not talked about as much as they are lived, which means one may miss the point by focusing on the narrative only. For instance, African Christians may confess Christ during the day and consult diviners at night (i.e. they are day Christians). A pastoral counsellor therefore should know the worldview in order to listen for indicators in stories that can be probed in order to understand the underlying issues. Thus, though the value of stories is not denied, one should be aware that story analysis in Africa may be just the beginning.

Kasambala (2004:159-60), focusing on African diagnosis, proposed a useful six-phased model that offers guidelines on African assessment and interpretation. The phases are discerning, clarifying, interpreting, supporting, reflecting and responding. In his model Kasambala highlights important focal areas in interpreting African people's stories. However, what Kasambala, like other African counselling writers such as Berinyuu, overlooks or “over-assumes” is the crucial complexity of community healing in Africa. Louw (1995:42), in the article “Pastoral Care for the Person with AIDS in an African Context”, makes a valuable point but also adopts this over-assumption. He states:

*For recovery, a pastoral approach should move away from a one to one pastor-patient relationship. And individual approach should be supplemented by group counselling, which must include **the family, the social group and other important figures in the community as part of therapeutic process**. The network of relationships from the sickbed to the family, from the hospital to the community is even more important the traditional bedside counselling with patients (Louw 1995:41, my emphasis).*

Pastoral healing in Africa is impossible if the counsellor does not determine either the positive or negative effects of the affected person's community (network of relationships).

One major reason that causes Africans to oscillate between Christianity and traditional practices, thereby hindering Christian healing, is community (extended family) pressure. When one goes through sickness and suffering, the pressure to conform to community advice and practices that may be against Christian healing is very high. Refusal to conform may cause expulsion from the circle of relationships, which aggravates suffering. Ncube (2003:91) argues that African practices of coping with HIV/AIDS that are embedded in the realm of African home-based care practices are very valuable. The family or the community walks the journey (i.e. rituals and sacrifices) with the suffering person (HIV/AIDS) by being with the person, though the outcome may be inevitable. He adds that the presence accorded either by rituals or therapy confirms and confers some dignity on an infected person. In these stages the person is never alone, confined in a hospital isolation room or hospice, but is always in the presence of loved ones. He added that over and above this, there is an explanation, through divination, of the who of one's situation.

Ncube, like other African writers, rightly identifies the crucial support and buffer that the African community provides, but overlooks its downside also. An individual is obligated to conform. Ncube observed that it is imperative that an individual remains in peace with other living and the living dead; they deserve attention from an individual within the community (Ncube 2003:91). Mbiti's (1975:2) comment is key to understanding this African dynamic:

*A person cannot detach himself from the religion of the group, for to do so is to be severed from his roots, his foundation, his context of security, his kinships and the entire group of those who make him aware his existence. To be without one of these corporate elements of life is to be out of the whole picture (1975:2).*

Mbiti's observation clearly underlines the magnitude of the pressure that the African community can exert on an individual who is part of the system. Often the person conforms.

Msimang (1975) and Lamula (1963) cited by Ncube (2003:95) noted:

*It is in self-respect and performing one's duties that ikhaya (home) is dignified and its members are protected from all kinds of evil. In the spirit of inhlonipho nokuzinhlonipha (respect and self-respect) an individual within the family has responsibility to carry out his/her duties, that is, to behave according to the norms and traditions of the family.*

The contentious issue, however, is: what if the respect, responsibility/duties or norms that one is expected to uphold are contrary to Christian values or principles of healing? Thus, it is difficult for an African to hold exclusively to

biblical teaching and God in sickness and suffering. This, therefore, in an African context poses enormous challenges to pastoral care. Pastoral care is much more complex and challenging than one may envisage.

The challenge in pastoral care and counselling lie in confronting the person's worldview in order to conform to biblical thinking, while at the same time there is extended family and community pressure. Whichever decision the person makes is painful. Should he follow biblical thinking and go against the community elders or should he follow the elders and forsake the faith? Therefore, pastoral counselling diagnosis should listen and probe the counselee in order to establish the intensity of this conflict.

The congregational systems counselling approach, however, is the most appropriate for Africa. It views a person not in isolation, but within a network of relationships. Everything that exists is in an ongoing mutual relationship with everything else. Systems thinking means that pastoral care should not only take note of the individual, but the position he holds within a relationship (as discussed in Chapter 4). Therefore to break this relationship means you are cut from community support. Pastoral care among the sick and suffering that embraces biblical thinking and appropriate God-images in Africa could entail conflict with the network of relatives and traditional practices. The person risks being cut off. Pastoral care (i.e. *koinonia*) therefore should always be ready to buffer the person materially and spiritually. This entails creating a hope support base. *Koinonia* should replace the broken network with relatives, but at the same time the person should not become detached from his or her relatives.

However, clearly, the African notion that an individual does not exist on his/her own for a person is a person through and with others (*umunthu ungumuntu ngabantu*) is valuable for the Church. In the Christian tradition Christians live as the body of Christ (1 Cor 12), which encourages connectivity among congregational members (*koinonia* system), thereby providing support for the suffering (HIV/AIDS affected people). Furthermore, the tradition of being present and observing someone who is sick makes it imperative, deriving from culture and Scripture, to be present or continuously visit the person living with HIV/AIDS. Also, the practice of according a person respect and dignity throughout life, preventing the person becoming a wandering spirit because he/she was not given love, can be harnessed to encourage acceptance, love and care, and avoid the discrimination against and stigmatisation of people living with HIV/AIDS.

However, the question we may pose is: what issues should an African pastoral counsellor focus on during pastoral analysis to unveil the influence of network of relationships? And what are the possible questions that can be asked?

The table below shows examples of questions that an African counsellor may ask to determine the influence of the network of relationships.

### Focal pastoral assessment questions in Africa

<b>Family background, upbringing and social interaction</b>	1. Are you the first Christian in the family?	Yes	No	
	2. If yes in 1, how supportive are your parents of Christianity?	No	Little	Very
	3. Are your parents first Christians in the extended family	Yes	No	
	4. If yes in 3, how supportive is the extended family?	No	Little	Very
	5. Did you ever participate or witness an ATR ancestral ceremony with parents?	Yes	No	
	6. If yes in 5, how often?	Once	A few times	Many times
	7. Are you and your family dependent on, or influenced by, the extended family?	Yes	No	
	8. If yes in 7, what is the level of influence?	Little	Moderately	Very
	9. Did you grow up in a city or rural village?	City	Village	
	10. If a city in 9, how often do you visit the rural village?	Never	Once a year	Two or more years
	11. Which type of school did you attend?	Government	Mission	Private
	12. To what level did you attend the school in 11?	Primary	High school	
	13. What is your level of education?	Less Grade 10	Matric	College/university
<b>Religion</b>	13. Do you believe in dreams?	Yes	No	
	14. If yes in 13, how strongly?	Little	Moderately	Very
	15. Do you believe in supernatural (ancestors, spirits or witches) influence?	Yes	No	
	16. If yes in 15, how strongly?	Little	Moderately	Very
	17. Do you think Christianity is a Western religion?	Yes	No	
	18. Do you think there is, or can be, a relationship or link between ancestors and Jesus?	Yes	No	

	19. Do you remember the circumstances of your salvation?	Yes	No
	20. Why do you think you are a Christian?	Testimony!	

### **Interpretation and analysis of the questions**

The above questions may help in interpreting stories and probing in the following ways.

If a person is the first Christian in a family, it may mean a lot in an African context. The person might have grown up immersed in African traditional practices and when he/she experiences suffering, the temptation to turn back is strong. The parents, who may not be Christians and are applying pressure to recant, may exacerbate this. The person may end up oscillating between two worlds (syncretism), thereby hindering healing. The same may happen to the nuclear family. If the family of the sick or HIV-infected person is the first Christian family in the extended family, the opposing pressure can be great. When suffering or a crisis such as death occurs, the extended family may be apathetic, since they believe the person invited trouble for him-/herself by forsaking the traditions. This may intensify and aggravate the suffering.

People in African contexts who often participate in or witness traditional practices may consider them a solution in times of sickness, the HIV/AIDS crisis and suffering. When the extended family's influence is high on the nuclear family, there is greater pressure from the extended family to seek alternative means to resolve the crisis and suffering. The environment also exerts considerable influence. Traditional practices do not have a very strong influence on Africans who grow up in cities and are exposed to the Western culture. However, this assumption does not always hold, so the counsellor should probe further. Nonetheless, though urban people are less influenced by tradition, this does not in any way suggest that they are more spiritual. They may not be Christians, but they lose the traditional influences. Schools attended and the level of education may also be an avenue to explore. People who have attended mission schools (i.e. church-owned schools started by missionaries) are normally more exposed to Christianity than those who attended government schools. Private schools indicate a high social status and these scholars could reflect a loose attachment to traditional practices. Furthermore, the traditional ties of those who study to up a tertiary level are weakened.

Strong beliefs in dreams, ancestors, spirits or witches are a big hindrance to Christian healing. The people with such beliefs are more likely to be tempted to seek traditional solutions to problems. When there is scepticism about the Bible and Christianity, this certainly means that influence of the God of the Bible and the acceptance of Christianity are limited.

These suggested questions for diagnosis to analyse African's stories and responses are merely an example of how a pastoral counsellor might probe during a counselling encounter. They are applicable to different kinds of sicknesses. And since HIV/AIDS can be perceived in the same way (as argued in Chapter 2), they can also be adopted by HIV/AIDS counsellors. However, the questions are in no way to be adopted prescriptively, nor have they been validated by empirical research. But it is certainly advisable to use them, since they may open many other avenues that would indicate where the counsellee stands spiritually.

## 5.4 Summary and Conclusion

This chapter argues that pastoral counselling is the most appropriate approach that can satisfactorily and meaningfully deal with the plight of HIV/AIDS affected people. The professional pastor is not the only pastoral caregiver and counsellor, but the faith community (*koinonia*) also - from the time a person is diagnosed HIV positive until death.

It emerged from the discussion that:

- ✧ Pastoral care and counselling referred as *cura animarum*, which is a classical formulation of pastoral work, denotes the special process of caring for human life because God created it and the people belong to Him. The task of pastoral care and counselling has shifted from the professional pastor to the mutual care of believers (*koinonia*). While the psychological counsellor requires many years of university study, pastoral/Christian care and counselling is a faith community enterprise. Every Christian comforts and encourages. The pastoral counsellor always approaches people in terms of grace and love (*agape*). This means the faith community accepts the person living with HIV/AIDS despite his/her situation. Pastoral care approaches the person holistically and fosters hope and meaning through the voice of the Gospel.

Through the pastoral shift from the professional consulting room approach to the faith community (*koinonia*), the *koinonia* would view itself as key and central to providing support and healing to people. Community (*koinonia*) healing results within the system where faith community members share their lives, accept and assist one another despite the HIV/AIDS condition. As a system, the faith community views itself as one, and when one member is infected or hurting they all share in it.

The *koinonia* in its quest to mutually support and care for its members, especially the HIV/AIDS affected persons, should embody the pastoral care metaphors of shepherd (God's care), suffering servant (God's identification with our suffering through Christ), wise fool (wisdom) and *paraklesis*



(God's comfort, guidance and direction, and advocacy). Though God is the Person who can fulfil these metaphors, the *koinonia* as a transformed pneumatological community should embody/concretise these metaphors for one another and those outside. Thus HIV/AIDS affected people who are often discriminated against and stigmatised, which aggravates suffering, should be accepted, cared and comforted by the *koinonia*. The *koinonia* fulfils this crucial care and support function by identifying (through empathy) with the infected people. The *koinonia*, therefore, through embodying pastoral care metaphors, becomes a healing community.

However, of these metaphors *paraklesis* is the most appropriate for HIV/AIDS pastoral caring among the poor. The *paraklesis* comforts and guides through applying the gospel to the despairing person, which brings healing and peace. But apart from applying the comfort of the gospel to the sufferer, the *paraklesis* advocates for the poor whose rights are often not upheld and their voices not heard. Thus HIV/AIDS pastoral care in Africa goes beyond meeting in a room and talk, but it may entail directing people (linking people) to places where they can get assistance, which could be government social welfare, relevant NGOs or where free ATRs can be obtained, etc.

- ~ The shift of pastoral care from the professional consulting room to the faith community (*koinonia*) is very important for African pastoral care in suffering and HIV/AIDS. It creates a link between *koinonia* care and the community and extended family care. Christians are encouraged to care for one another.

When people become HIV infected, the theodicy question springs to the forefront. Why me, God? And when an African asks the why? question, he/she may not be wrestling with a meaning issue, but asking a question that has an instant answer from a diviner or Sangoma. The why? in fact, should be preceded by who? Africans want to know "who" caused the HIV infection and "why?" Though they may accept a naturalistic explanation, it is always interpreted within the personalistic (supernatural) framework. Healing among Africans therefore may entail shifting from the supernatural worldview (cause and effect) to biblical thinking that does not answer every why question. Thus over and above the theological assessment of God images, faith analysis and religious analysis, an African counsellor should be able to determine/diagnose the intensity of African thought patterns (worldview) in order to offer meaningful, effective and relevant counselling to people living with HIV/AIDS. At times community (system - relationship network) influence plays a very negative role by exerting pressure on the person to conform to traditional practices that conflict with pastoral/Christian mode of healing.

The African pastoral counsellor, therefore, through a congregational systems approach, should be able to erect support structures, which bring healing, for people who may be cut off from the network of relatives because they may be regarded as deviant due to their Christian convictions. And for those who oscillate between the two spheres, the counsellor should be patient with them as they contemplate the opportunity cost of their actions. Being cut from traditional support structures entails great pain, because for Africans “a person is a person because of others”. Hence being cut off seems like the end of life, since soulfulness (quality of life) is about relationships and networks. *Koinonia* care therefore provides crucial support and cushioning in this situation. It should replace the broken network. At times it may entail that some faith community members (*koinonia*) temporarily adopting the affected member until the situation calms down. Pastoral care (*koinonia*) in Africa is therefore arguably the only structure that can replace the extended family if it collapses or is strained.

- ☞ The task of counselling entails building a relationship (counsellor and counselee) where the counsellor facilitates the counselee's growth. Within the African framework, however, counselling is equated to divination (Berinyuu). The counsellor (diviner) listens to and interprets people's stories and African counselling often takes the form of advice counselling (wisdom and direction). But, importantly, HIV/AIDS counselling should involve a communal structure.

HIV/AIDS counselling is geared towards facilitating the counselee's quality of life by helping him/her to manage problems and to cope after the disclosure of their HIV-positive status. However, hope in life after infection requires a more holistic and reassuring approach than Rogerian client-centeredness. Pastoral counselling is therefore more able to deal with the plight of people living with HIV/AIDS. A person living with HIV/AIDS person is facing death and he/she asks questions related to God and soul, life and death, condemnation and forgiveness, etc.; pastoral counselling (therapy) is the appropriate discipline that is equipped to deal with these issues (death, ability to instil strong hope and meaning that transcend the present situation and anticipate the ideal). Pastoral counselling to people living with HIV/AIDS transforms their human existence so that victory over sin and death becomes a reality, which imparts meaning to life.

HIV/AIDS pastoral counselling is not just a deathbed ministry, where the pastor is sought to minister to a person dying of HIV/AIDS. It is a daily ministry that offers positive orientation to life through eschatological hope. The person living with HIV/AIDS suffers from guilt, despair, anxiety, alienation, and the list can go on, but it is only through God's fulfilled promises regarding salvation that “restoration, peace, integration and

conciliation” are found. As HIV/AIDS care focuses on the infected person, it is crucial to communicate the message of hope. God’s faithfulness (applied contextually), such as, “I will be with you (Matthew 28:20)” and “the Lord is my shepherd (Psalm 23)”, guarantees God’s presence in the midst of HIV/AIDS uncertainty. As a faithful Shepherd God is always with his people, through gospel wisdom and insight we know that even in the HIV/AIDS condition He (God) is sovereign and knowing. A life surrendered to the arms of God, coupled with this understanding, attains a measure of stability, thereby bringing healing. The person living with HIV/AIDS therefore would live his/her life beyond infection positively, which is crucial for physical healing. So, both horizons of hope (the immediate and future) are merged in pastoral counselling.

Pastoral counselling (i.e. church - *koinonia* care) should not only concentrate on inculcating God, who identifies with people such as those in the HIV/AIDS condition, but should embody the care metaphors. These metaphors should be perceived in communal terms as in the African context, which challenge and encourage mutual care and interdependence of believers. This practical approach to the affected people foster a God-image of God who is a Friend, Partner and Companion for life through the “being there” of *koinonia* in HIV/AIDS affected people’s situation. In this sense therefore someone in Africa who may have tension with the traditional community may find a “hidden nest” among fellow believers. They encourage him and are his companions, thereby replacing the healing role of the traditional community and extended family.

- ✿ In pastoral counselling the relationship between the Bible and psychology should be handled carefully. Louw refers to these epistemological sources as being in tension, which he terms “bipolarity”. He views this tension as healthy, since these two horizons never merge. Psychology operates from below, while Scripture (revelation) comes from above. The bipolarity can only be resolved through convergence. In the convergence model pastoral care and counselling are viewed as a unique theological perspective, i.e. eschatology determines it. Eschatology signifies our new being in Christ, as well as the revelation and fulfilment of our future in terms of the coming kingdom. Hence pastoral care within perspectivism is inevitably connected to hope. The exercise of pastoral care is a sign of hope to the world. This hope is the fountain of peace and motivation to live in this life, even within the HIV/AIDS condition. Within perspectivism the Holy Spirit, who is the counsellor and comforter, guides and empowers life and emanates from the victory on the cross. The Holy Spirit is therefore central to the perspective model. The eschatological perspective to HIV/AIDS-affected people provides a horizon of meaning, links the person to the faithfulness

of God, creates a normative framework, and imparts a unique identity to the counselling act as the counsellor acts from a faith dimension.

The centrality of the cross and the emphasis on hope in a convergence model provides a framework for understanding the suffering of the patient beyond the stigmatisation paradigm of people living with HIV/AIDS, which encourages *koinonia* acceptance and involvement. In his introduction to *A Theology of the Cross*, Cousar (1990) states emphatically that the cross confronts us. This is indeed so with an eschatological perspective, which criticises human complacency, selfishness and loveless self-assertion. With trust in a transcended God, the community of faith (*koinonia*) should be steered to self-sacrificing service and unconditional love, thereby sharing with those in the shackles of HIV/AIDS hope for the future, gratitude and joy (doxology) for the historical event of the cross. The church should therefore march on into the community and have an impact on people's lives by being God's kingdom's exhibits of mercy and compassion.

- HIV/AIDS counselling takes place in two categories, i.e. pre- and post-HIV test counselling. The pre-test counselling is to find out why individuals want to be tested, the nature or extent of their risk and to prevent further infection. The post- test counselling seeks to erect support structures if the person is HIV positive, but for the negative person, it educates the person in how to live safely thereafter.

The discussion in this chapter highlighted that pastoral care is uniquely the best counselling approach that can meaningfully address the plight of HIV/AIDS-affected people in Africa. And the faith community (*koinonia*) is the vehicle that provides the pastoral care.

But then, how can a model of HIV/AIDS ministry be designed in such a way that the congregation (*koinonia*) becomes a crucial vehicle of HIV/AIDS support (care and healing) among its members and the community (society)? Can home-based pastoral care be designed within a congregation to ensure that many HIV/AIDS-affected people in and outside the church are reached? Why is congregational (*koinonia*) care arguably the best responsive and suitable paradigm that may effectively and meaningfully provide care and support to HIV/AIDS-affected people in Africa? How can home-based care be designed in such a way that the congregation plays a central role in addressing the plight of the poor and HIV/AIDS affected people? These questions introduce us to the next chapter.

# VI.

## *Home-Based Care: A Responsive Paradigmatic Approach to the HIV/AIDS Pandemic in Africa*

### *6.1 Introduction*

Chapter 2 outlined the HIV/AIDS scenario in Africa; Chapter 3 delineated the interplay between poverty and HIV/AIDS in Africa; Chapter 4 highlighted the church/congregation as a practical theological instrument of care to the poor and HIV/AIDS through its designation of family system; and Chapter 5 focused on HIV/AIDS counselling within an African setting. It underlined the key role of the faith community (*koinonia*) care in pastoral care. Thus these chapters have set out the African HIV/AIDS context and the possible church intervention. However, the question is: how?

It is a fact that in Africa there is a shortage of medical resources in health care delivery systems. It is extremely difficult to ensure that care is truly patient-centred, that the patients' worries are heard and addressed in a timely fashion – and that care is continuous. HIV/AIDS care entails not just a single visit but is an ongoing process, which “threatens to sink the Titanic on her maiden voyage” (Dr Prabhu in Smart online). Patients are scattered in different places with problems of access. The personnel involved visit the sick only when they have finished their routine work (if they ever get to do so!) and often end up visiting and offering assistance at their own convenience rather than that of the patients (Smart online).

In fact, it has been estimated that 50% - 60% of people with HIV/AIDS worldwide have no access to professional health care workers to address their medical needs. For example, in Uganda 88% of the population lives more than 10 kilometres from any kind of health facility and the nurse to patient ratio is 1:4300 (Smart online). Therefore the care that is normally provided is informal in the home, with family members getting very little support. Government officials and many other organisations are usually out of reach for poor people and yet the scale of HIV/AIDS devastation is enormous. And in most cases the church is the only institutional structure in such poor communities. Hence, we may ask: how can the church provide home-based care support system to these affected people?

The central focus of this chapter therefore is to suggest a model designed for HIV/AIDS home-based congregational (*koinonia* - system) care ministry. It argues and hinges on the assumption that, for home-based care to be successful, the concept of family (system) adopted by *koinonia* should be central in driving home-based care ministry. This functions by working, linking and incorporating the informal home-based care providers.

## 6.2 *The Church as a Subsystem within the Community*

Berinyuu (1989:7), in his research done in Nigeria (referred to earlier), but which is likely to be applicable to much of Africa, showed that when Africans are confronted with crisis and suffering 55% seek African therapy, 12% seek pastoral counsel, and 33% seek a Western-trained counsellor. African therapy refers to healing solutions sought in the context of the family, i.e. extended family head, parent, family friend and family meeting. Berinyuu explained that the lowest preference for the pastor does not necessarily mean that people do not like the church. An important reason why the pastor is least preferred is that in mainline churches there appears to be a reductive approach to people's problems, which explains away the religious experiences and expressions of the ordinary people (1989:8). Mwaura (2000:93) and Kiriswa (2002:26), therefore, underlining the centrality of home-based care in Africa, argued that counselling in the traditional African society takes a communal approach in which the immediate family community is deeply involved.

Mbiti (1975:108), commenting on "the family, the household and the individual" in Africa, expresses an idea that may also underline home-based care as ideal and successful in Africa. He states:

*Only in terms of other people does the individual become conscious of his own being, his own duties, his privileges and responsibilities towards himself and towards other people. When he suffers, he does not suffer alone but with the corporate group; when he rejoices, he rejoices not*

*alone but with his kinsman, his neighbours and his relatives whether dead or living.*

The African church should tap these advantages in designing home-based care ministries. But the question is: how? Vos (2003:232), confirming our argument in Chapter 4 of church family systems, also suggests a “family metaphor”. Thus “in this situation the family as metaphor could provide a focus for guidelines for the church in South Africa” (2003:232) and the rest of Africa.

The congregation/church family system is one made up of individual family systems. Church members who converge for worship on Sundays and other days come from a culture of networks of relationships (extended family). This culture of networking therefore should be encouraged. In fact, members are already in a network in African churches. This is evidenced when one attends a church service in an African community (especially in the rural areas), where members address each other as uncle, nephew, etc. Though these people may not necessarily be related, addressing one another in relational terms brings closeness and bonding. Louw (1995:42), in *Pastoral Care for the Sick with AIDS in an African Context*, rightly observed that one can easily link up meaningfully with the African’s understanding of himself with roles and societal relationships by referring to the Church as a body with *koinonia* ties. *Koinonia* imparts a role of loving service amongst believers. The for-each-other formula within *koinonia* creates a network of caring relationships.

Therefore the direct link of the extended family system with a congregation is, as Augsburg (1986:179) suggested, that a church system is a subsystem of the community and the community is a subsystem of the society, and these systems always influence and borrow from each other. The African church borrows from the rich elements of the notion of the extended family, while Scripture also reflects the features of the extended family. The high-risk practices that may fan HIV/AIDS (as discussed in Chapter 2) should be discouraged, but those that promote mutual care – like being together in sickness and crisis to share the pain and encourage healing – should be encouraged.

Thus, while we should bear in mind that African practices may not always or directly translate to Christian practices to result in effective home-based care, as noted in the possible conflict between African counselling and pastoral counselling, there is reason to contend that African practices can be harnessed by the church, since African peoples are the building blocks for the African church. But we may ask: how then does a systems approach link with the notion of home-based care?

### 6.3 *A Systems Approach and the Principle of Home-Based Care*

A systems approach, as argued in Chapter 4, refers to members who do not function independently of one another but as a unified whole. The parts are connected by a central sense of oneness. Scripture underlines this sense of oneness through metaphors and images. And among the many metaphors we have identified is the family. This connectivity in Africa is seen through the extended family network. The members' interdependence and networking, as Scripture teaches, should be maintained by the bond of love (Jn 13:35, 15:12).

The love (*agape*) connection between members entails selfless service (*diakonia*). Each member does not only seek to please the "I" but "us", which sustains the system as a whole. Thus, as a system, Christians are challenged to focus not only on the individual but on others also. This communal fellowship (*koinonia*), however, goes beyond sharing faith and doctrine to mutual material obligations towards one another (Acts 2; James 2; 2 Corinthians 8). The systems approach entails that Christians (God's family members) as a connected group accept and embrace one another, which dispels stigmatisation and discrimination. The joys, sorrows, hurts, anxieties, etc. that each member experiences are shared. However, Christians as custodians of God's Kingdom, in addition to focusing on one another (i.e. only *koinonia* - Gal. 6:10), should demonstrate (embody) the Kingdom to the people outside the church (community and society). Thus the twin Christian responsibilities - to one another (Christian care) and to the outside (society at large), i.e. gospel - nurture and provide material support for the former and gospel sharing and material support for the latter.

Therefore, what do the systems approach and the biblical model imply for care to person(s) suffering from HIV/AIDS? A person living with HIV/AIDS suffers from physical crisis, emotional crisis, relational crisis, identity crisis, existential crisis and spiritual crisis (Porte 2003). Conflict appears with your body that lets you down. Your body can't do what it used to do. There is also conflict with yourself about what you did. The life-threatening nature of HIV/AIDS brings torment and distress (emotional crisis). There is denial, anger, fear, guilt, loneliness, depression, acceptance, fear of rejection by other people, disappointment of others, fear of the painful process of dying, etc. Relational crisis results from the stigma attached to HIV/AIDS; the secrecy that may cause isolation, and family and friends may be confronted by the person's emotional behaviour. Identity crisis results from the questioning of the person's worth, acceptance, functionality, etc. Existential crisis develops from the life-threatening nature of HIV/AIDS. The person loses the meaning of life as dreams, hopes and goals are shattered. Spiritual crisis results from feelings that God has turned his back on the person or from thinking that God is



punishing him. Furthermore, there are the following losses – physical abilities, financial means, employment, friends, etc.

Amid all these problems associated with HIV/AIDS, the systems approach – i.e. faith community (*koinonia*) care – entails that, as the person experiences the conflicts and losses, the community should be present to assure the person of their support emotionally and materially. In deep emotional crisis the community should guide and go through the painful process of denial, anger, guilt, loneliness, depression and acceptance with the person. They should always be there to be the emotional buffer. As the person experiences an identity crisis, the identity that is affirmed by the community should be emphasised, i.e. you are not alone – not “I” but “we” – we are all affected like you by HIV/AIDS; as Ackerman says, we are all people with AIDS. The community should assure the person of their love and acceptance as a system to ensure a warm and close relationship. Existential crisis should be addressed through the gospel promises that the community actualises through unconditional acceptance and love of the person.

The connectivity of Christians therefore ensures that those who are unconditionally accepted as part of the system are not stigmatised. Thus the systems approach dispels stigmatisation. The system views whoever is living with HIV/AIDS as “us” not “them”. Such an acceptance helps the people to feel a sense of warmth, worth, dignity, love and belonging. Thus the faith community not only talks about God, but also demonstrates the love of God to others, which is crucial for home-based care.

Having considered the church as a subsystem of the community and the implications of a systems approach to *koinonia* mutual care, which has direct application to congregational home-based care, we should now focus on home-based care. The question we may ask is: what is home-based care and how does the church – *koinonia* (congregational) care – fit into this framework?

#### *6.4 Definition and Description of Home-Based Care*

Home-based care, as the name indicates, refers to care and support provided to a person while he/she is in the home with his/her family, friends and community, i.e. family caring system. MAP International (1996: Module 8), at a basic level, states that:

*Ideally, the family should provide the care, but friends or the church can also provide care. Anyone can provide the necessary care - there is no need for any specialised training. Anyone who can show love in a practical way can do home-based care.*

MAP's definition is correct but simplistic. There should be a deliberate attempt to ensure that home-care providers become skilled. Van Dyk (2001:327) defined home-based care specially focussing on the community tangent as follows:

*Community home-based care is the care given to individuals in their own homes when they are supported by their families, their extended families or those of their choice (Van Dyk 2001:327).*

However, Smart (Online) offers the following comprehensive definition:

*Home-based care is the provision of comprehensive services (including health and social sciences) by formal and informal caregivers in the home, in order to promote, restore and maintain a person's maximum level of comfort, function and health. Usually, these are initiatives from NGO, community-based organisations or faith-based initiatives but they require sufficient support and funding to be sustainable. In resource-limited settings without adequate health care infrastructure, these services are not just needed for end of life care, but throughout the course of illness. They are often the only way to deal with a patient's ongoing and emerging symptoms where diagnostic and treatment resources are limited.*

Smart's explanation of home-based care captures all its dimensions, and importantly, its central role in poor communities where medical facilities are scarce.

Sister Hillery (2002:2) of Lusaka Archdiocese, in her research paper presented to the Justo Mwale Seminary entitled "The role of community home-based care within the church," stated the goal of community home-based care as "to lessen the impact of HIV/AIDS in the community, and to provide whatever care and support is required by people infected and affected by the HI virus." On the same note, MAP International (1996) views the aim of home-based care as allowing people living with HIV/AIDS to stay at home and not to go into hospital, to encourage and enable the family to care confidently for the person living with HIV/AIDS, and for the person living with HIV/AIDS to be as comfortable as possible, even to the point of death.

The AIDS Support Organisation (TASO) in Uganda outlines the home care provided as "counselling, information, medical and nursing care, and material assistance" (United Nations 1998:15). Jackson (2002:232) added:

*These services also provide valuable opportunities for awareness and prevention, for preparation for care of orphaned children, and for promoting legal rights around property, sex and other areas.*

A team that can render the caring services may include:

*A medical practitioner, nursing supervisor, social worker, health educator, physiotherapist, occupational therapist, AIDS health promotion workers, volunteers, traditional healers, religious healers and religious leaders (Frohlich 1999:4, cited in Van Dyk 2001:327).*

The services that home-based care provides correspond in many ways to pastoral caring, especially general care and concern for human life, and counselling. Therefore, the church cannot afford to fold its hands when there is such a great opportunity to show mercy and compassion, i.e. to demonstrate the kingdom of God in people's homes. Home-based care, therefore, should be a concern for all Christians (*koinonia*) and the other people. Besides, the Church is the Christian family, though not to the neglect of the blood family. "Therefore, as we have opportunity, let us do good to all people, especially those who belong to the *family of believers*" (Galatians 6:10) [my emphasis].

In home-based caring, care and support (the focus of the caring exercise) are directed towards three groups: people living with HIV/AIDS (the infected), the family caregivers (the primary caregivers – which could be the neighbourhood or community), and the children of the household (MAP International, 1996: Module 8; Bor and Elford 1998: xxi-xxiv).

Home-based care was being practised many centuries ago (MAP International 1996: Module 8), but the care that used to be provided was safe. People could provide nursing care with peace of mind. However, HIV/AIDS home-based care is different. Care providers can easily be at risk. Necessary protective clothing, such as gloves, is needed and necessary precautionary skills like washing wounds should be learnt. Apart from the challenge of acquiring the right resources, care is more stressful as the infected person feels that he/she is living on borrowed time. Time will be ticking away and the person's health will be deteriorating, hence triggering unprecedented anxiety, despair, stress and depression. Caring, therefore, becomes an enormous challenge. The HIV-positive person further strains the family's resources and drains them emotionally. Therefore, home-based care is a challenge.

Home-based care should not and cannot be restricted entirely to health professions, especially in Africa, where medical resources are scarce. It should also be viewed as a community function, in our case the faith community. If it is viewed as such, all people would view themselves as responsible for providing care, which is vital. Such an understanding would arguably have a significant effect on the people, since they would view HIV/AIDS care as an extension of the caring services rendered to one another in the family and community (i.e. both congregation members and wider community). However, though home-based care should not be the sole responsibility of the health

professions, for the sake of referrals and expertise there should be a very close link.

But how does the church/congregation fit in as a home-based care provider? Is there a model that incorporates the church?

### 6.5 *Different Models for a Home-Based Care Approach*

The seriousness of the HIV/AIDS pandemic has forced people to change paradigms, i.e. from curing to caring.

*As early as 1986, the committee on a national strategy for AIDS (CNSA) for the USA described the system of AIDS care in terms of three components, namely hospital care, out-patient care, and community care (Uys 2003:4).*

“Hospitals” diagnose and perform in-patient therapy and discharge patients with the intention of integrating them with out-patients and community agencies. “Out-patient” services are responsible for the medical management of patients together with an AIDS-related complex, delivered by dedicated AIDS clinics, as well as counselling and health education. “Community-based care” is care occurring at patients’ residences to supplement or replace hospital-based care with palliative care by means of social support.

The strain on hospital care that has led to home-based care is not only a concern for African governments’ poor health delivery systems. In fact, home-based care programmes formally began in North America and Europe (as noted above), when it became clear that hospital care was too expensive, and that families and other carers found it difficult to cope on their own with the demanding care of people living with HIV/AIDS (Uys 2003:4).

The high cost associated with medication is a widespread problem in Africa, especially in the context of general poverty. In a study on home-based care in South Africa, it was found that poverty is one of the aspects of care that community caregivers found the most difficult to handle (Defilippi 2003:162). Coming into households to assist with care and finding families hungry and cold, without hope of relief, is daunting. If this happens daily, it may lead to burn-out. These affected people require support. Pastoral care (*koinonia*) could certainly play a crucial role in providing this support.

Home-based care systems fall into three categories. Uys (2003:5) identified the three different systems (models) of home-based care that have been developed as “integrated home-based care, single service home-based care, and informal home-based care”.

- ∞ *Integrated home-based care:* Integrated home-based care works by linking all the service providers with their families in a continuum of care - from diagnosis until death. It attempts to enhance support and collaboration between different components (families, community caregivers, support groups, NGOs, and community-based organisations). In this model, referral is done between partners as trust is built, and it develops capacity in all partners. Louden (1999, cited by Uys 2003:6), adds, “All care is given based on palliative care standards.”
- ∞ *Single service home-based care:* In single service home-based care, one service component (a hospital, a clinic, an NGO, or a church) organises home-based care by recruiting volunteers, training them, and linking them to HIV/AIDS-affected people and their families in the homes.
- ∞ *Informal home-based care:* In informal home-based care, families care for their members at home with the informal assistance of their social network. Nobody has any specific training or external support, and there is no formal organisation.

*Evaluation of the models:* A brief evaluation of the above models could be an eye-opener to possible complexities associated with each model in most African families affected by HIV/AIDS. The “integrated home-based care” model that Uys considers ideal is highly theoretical and hypothetical. Its applicability in the case of poor families is suspect. In many poor African homes, especially in rural areas, clinics are often many kilometres away from the people’s radius. People have to travel many kilometres to a clinic and when they arrive there, there are usually no drugs (Defilippi 200:162-166; Smart 2003:174-180). In many instances the clinics are staffed by very few nurses, who cannot afford to spend time on home-based caring. For instance, in Uganda the nurse to patient ratio is 1:4300 (Smart online). Therefore, though the model would be the ideal and most effective, its application remains a dream for many HIV/AIDS affected people in contexts of poverty.

“Single service home-based care” would be a valuable model in a community, especially if a church starts it. Churches are strategically distributed in many contexts and are in contact with the community. In fact, churches are the only community institution apart from the school in many poor African communities. However, hoping for a hospital or clinic to start home care would be impractical. Hospitals and clinics are scarce, so how could they start applying home-based care? Under this model some non-governmental organisations are doing commendable work and churches should join them in their quest to reach, care and support HIV/AIDS affected people. ***This research therefore argues for this model - single service home-based care referred to as congregational home-based care.***

The preference for congregational home-based care (i.e. single service home-based care) goes beyond the strategic location of churches. The church in any community is perceived as a caring community and many organisations (especially NGOs) use it as a locus of distribution. It is generally a credible institution that connects the community with outside agencies. Therefore it is suited to provide the twin intervention of HIV/AIDS caring and poverty alleviation.

“Informal home-based care” is the practical situation in most poor African homes hit by HIV/AIDS. Family members go it alone with no education and skills. And, in the process, some are also infected as they ignorantly show mercy and compassion to their beloved relatives in practical ways. Because Africans are generally communal, the family may occasionally get support from the neighbours and community, who also have limited knowledge on standard care. Hunter (2001:203) observed that throughout the HIV/AIDS pandemic, most of the services provided to HIV/AIDS-affected people and their families and children in developing countries have been provided by local systems<sup>1</sup> of care, which is informal home-based care. The local system in Sub-Saharan Africa is responsible for 95%-98% of all care (Hunter 2001:206).

The paradox in informal home-based care, however, is that women are poorer than men and yet they are the ones that provide most of the home-based care. The AIDS Bulletin (2004:18) highlights the idea that traditionally men are not society's caregivers; that responsibility is normally the burden of women. The study at KwaZulu Natal University cited by the Bulletin reports that 41 informal caregivers interviewed (which is a very large proportion in the research!) demonstrated the consequences for women providing community volunteers or primary caregivers. The wellness of their families is negatively affected by the care they provide and poverty is deepening.

The informal home-based care, therefore, in order to provide effective care and address poverty, should be linked to a single service home-based care, which strengthens the case for a congregational home-based care linked to informal home-based care providers. The model therefore being suggested or argued for is one that links the church and homes. It attempts to integrate informal home-care providers and the church caring ministry. However, though this model sounds like “integration”, it is different from Uys's integration in which affected families are always linked to health facilities. It can only be called “integration” in the sense that it integrates the church and the traditional

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<sup>1</sup> A local system of care includes the goods and services provided by children, families and households that are residents of the community. Some of these services may be provided by local CBOs that have specific goals and objectives. Government and NGO services in a geographic area may provide support to a local system. A local system of care is voluntary and an integral expression of the social structures in the community. It may or may not be formally organised, and exists as an outcome of social interaction in a community.

home, but it is more in line with “single service home-based care”, according to Uys’s classification.

The dire reality of poor people affected by HIV/AIDS should move the church. “When he (Jesus) saw the crowd, he had compassion on them” (Mt 9:36). These poor people need support. In *AIDS and the Church*, Shelp and Sunderland (1987:104) were quite right in saying: “AIDS ministries are primarily ministries of support, nurture, and consolation.” Wilson *et al.* (1996:195) make an additional point, namely that “caring for human needs is central to pastoral ministry”. The congregation/church within communities should look out for HIV/AIDS-affected people who are objects of compassion. Using the **“single service home-based care” model**, the church should work out possible ways of reaching HIV/AIDS-affected people in the homes of the community. This initiative by a congregation would certainly be crucial in providing support for “informal home-based care,” which is normally the case for poor people. These poor people have no external support (Uys 2003:7). **Thus “single service home-based care, i.e. congregational care” should be designed to assist families engaged in “informal home-based care”.** Smart is right that integrated community and home-based care are the most and cost effective approach to HIV/AIDS care. In *AIDS, a Manual for Pastoral Care*, Shelp and Sunderland (1987:37) outline the pastoral care support that the church can provide as follows:

*Support in turn may be offered at a number of different levels: physical or material, emotional or psychological, and what can be most simply identified as spiritual or religious support.*

Generally Uys’s home-based care models cover all home-based care. But Jackson (2002:238) also identified five models that could easily be considered in conjunction with Uys’s models. They are:

- ≈ The hospital mobile outreach model;
- ≈ The AIDS service organisation, non-government organisation, mobile outreach and community links;
- ≈ The church-based, community outreach;
- ≈ The community-rooted model developed within, and by, the community; and
- ≈ People living with or affected by HIV/AIDS networks and support groups in the community.

As the name suggests, the hospital mobile outreach is not ideal for poor communities, where roads are not well maintained and people are isolated or sidelined. Although it is easy to monitor and supervise, it falls short of reaching its target clientele. The AIDS service organisation, non-government organisation, mobile outreach and community link have poor hospital links,

but they provide valuable support through the people of the community. The church-based community outreach model provides an opportunity for the church to offer mercy and compassion to the community in a practical way. But if this is not done with love, the people may tend to moralise and increase the stigma. The community-rooted model, developed within, and by, the community may also have poor hospital links, yet it has valuable support networks. Lastly, there are the networks and support groups in the community for people living with, or affected by, HIV/AIDS. HIV/AIDS-affected people in these groups provide a strong healing link, as they share their experiences, but the community should not abandon them.

Jackson's models are not clearly distinct. She seems to duplicate them. They also overlap and they cannot be described and distinguished clearly, let alone be identified individually. But they illustrate what takes place in practice at grassroots level, though she does not clearly describe them theoretically. It is often difficult to hold to a single model without tapping from the others. However, for easy and clear understanding, Uys's models are better delineated and *single service home-based care* is a worthwhile model for a church to adopt and develop; therefore, it is recommended. ***Thus the congregational home-based care proposed in this research is a single service home-based care.*** But as mentioned, ***it should always be linked to informal home-care providers,*** otherwise it would be inapplicable and irrelevant.

The single service home-based care approach, however, should be developed in such a way that it assists and functions alongside families involved in informal home-based care. The church should keep its ears to the ground for families engaged in informal home-based care, so that the congregation can support them, as they have no support. These people should be incorporated into the church home-based pastoral care ministry.

The informal home-based care providers, who are usually poor people (and mostly women), if not linked to an institution-based care structure like a congregation, won't be noticed. These people can easily be overlooked and forgotten, hence they should be identified through the link between the community and the church.<sup>2</sup> The church should provide a voice for them and source material support on their behalf. The AIDS Bulletin (2004:13) argues that statistics available for orphans and vulnerable children probably underestimate the level of support provided globally, since small community-based support groups assist such children without donor support and do not report their statistics to a central database. Reports from governments and larger organisations indicate that less than 3% of

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<sup>2</sup> The church is made up of community people who are in touch with what is happening in the community where they live.



orphans and vulnerable children in low- and middle-income countries receive public support.

In fact, more in line with what the AIDS Bulletin (2004:13) highlights, there are people – especially women – who are struggling on their own in providing informal home-based care, which could be avoided through linking them to an institution like a church. Thus the strength of congregational home-based care is that it is a recognisable and visible institution that can source material resources and at the same time, through its members' network, can identify the needy in the community, thereby becoming a crucial channel and link to informal home-based care providers.

The previous discussion focused on the different home-based care models. Therefore it may be worthwhile also to consider why home-based care is necessary (i.e. its benefits/advantages).

## *6.6 Benefits/Advantages of Home-Based Care*

Home-based care is a less expensive way of caring for HIV-positive people than hospital care. However, the benefits go beyond financial and material resources. Uys (2003:5), Van Dyk (2001:328-329) and Smart (Online) list comprehensive benefits of home-based care that can be summarised by the following points:

- ≈ It allows the patient and the family time to come to grips with the illness, and the impending death of the patient;
- ≈ It is less expensive for the family, because problems such as transport to hospital, time spent on hospital visits, and other costs are reduced. Relatives can take care of the patient while attending to other chores;
- ≈ Care is more personalised, and people living with HIV/AIDS feel less isolated from family and friends;
- ≈ People prefer to face ill health and death in familiar surroundings rather than in a hospital ward;
- ≈ The totality of care is less expensive for the country than institutional options, since periods of hospitalisation are reduced;
- ≈ Family members are normally the ones who may be always willing and available to provide care.

Writing on *Doing a Home Visit* to HIV-infected people's homes, Marston (2003:115) commented: "Within their own homes, people living with HIV/AIDS tend to be more open about their emotions, fears, and needs than they are in the strange environment of hospital or clinic." She adds that it allows for a "realistic assessment of the people living with HIV/AIDS and family's holistic needs; and provides care and support that is suited to the individual

circumstances of each person living with HIV/AIDS" (2003:115). Therefore, in home-based pastoral care, visits in home care are crucial. In fact, in an African context a home visit proves that you value the person. Hence, this has an immense healing effect since people living with HIV/AIDS require acceptance and love.

Having outlined the advantages of home-based care, we proceed to suggest a design for a congregational home-based care model for ministry.

## **6.7    *Home-Based Care: The Ministerial Praxis of a Family and Systems Orientated Understanding of Ecclesiology***

### **6.7.1    Home-based care and social analysis**

For a church to start a home-based care ministry, it should be aware of the magnitude of the HIV/AIDS pandemic in the area (i.e. community). The congregation should study its environment to determine the people who require home-based care. Therefore to understand community needs Hendriks (2004:77-85), in *Studying Congregations in Africa*, suggests useful strategies or methods that Christians (congregation members) may adopt in order to be aware of their environment and hopefully intervene. Thus scope, visibility and invisibility, time line, space tour and weekly routines (2004:77-85) need to be considered. These methods may be applied in our context in the ways described below.

#### **6.7.1.1    *Scope***

The congregation, in its quest to offer HIV/AIDS care, should be able to describe its environment in detail. It should know its scope. Wherever the congregation is located, it should be aware of the macro (global factors), meso (e.g. groupings and institutions), and micro (influences surrounding the individual) factors that are surrounding it. For instance, a poor church with many HIV/AIDS-affected people in its locality (micro) should probably network with an NGO working in the area or government welfare to get resources for the needy people (meso), and the home care providers should always try to keep abreast with global HIV/AIDS research and developments in HIV/AIDS (macro).

#### **6.7.1.2    *Visibility and invisibility***

Visibility may refer to church buildings erected in a community, while acts of love and compassion by church members may not be readily visible. The congregation (church) within its community should be critical and sensitive to ensure that it never becomes complacent. For instance, the congregation

should be a hidden nest for the people living with HIV/AIDS needing hope. Therefore, though this may be invisible, it changes people's view of Christ and Christians (church), thereby being a witness and conduit of hope to the community.

#### *6.4.1.3 Time line*

To steer the congregation "On learning to see" (Smit 2003:55), the congregation may be asked to list the community social actions that they have been involved (in past and present). In other churches it may happen that they may not have been involved in any practical intervention on community issues. This therefore opens the congregation members' eyes to see how apathetic and irrelevant their Christianity is in the eyes of the community, e.g. on HIV/AIDS issues.

#### *6.7.1.4 Conduct space tour*

Space tour refers to church people or the pastor touring their environment. As one walks or jogs around the congregation's geographical area, one opens one's eyes to see - what people are doing, what people are eating, who stays where, who does what, etc. In so doing, one develops a vivid picture of the HIV/AIDS situation in the environment and where one may intervene to assist.

#### *6.7.1.5 Weekly routines*

This has to do with observing what goes on weekly in the community, e.g. where are young people attracted on weekends? Where do people normally socialise? Which hangout places are likely to facilitate the spread of HIV/AIDS? etc. This information helps the congregation to plan the activities that may impact on the life of the community regarding the HIV/AIDS pandemic.

There are many other strategies that congregation members may adopt to study their community environment and to remain informed of what is around them besides scope, visibility and invisibility, time line, space tour and weekly routines. But these methods provide a useful starting point for the congregation to be aware of the people around them who require assistance (i.e. HIV/AIDS-affected people).

After identifying the people who require home-based care, the congregation goes on to implement the ministry.

### 6.7.2 Implementing congregational home-based care in a context of poverty: issues and challenges

~ ***Issues at stake in implementing the home-based care ministry:*** Offering home-based pastoral care and counselling support is not easy. As Shelp and Sunderland (1987:37) point out, the task entails physical, material, emotional or psychological, as well as spiritual and religious aspects. Uys (2003:7) summed up the kind of support offered as: counselling and teaching, and palliative care. The support functions echoed by Shelp and Sunderland are contained in Uys's two functions.

Uys views counselling and teaching as important skills that home-based caregivers should possess. The objectives of this counselling and teaching are to promote a positive acceptance of diagnosis; promote disclosure especially to sexual partners and family caregivers; enhance the understanding of the illness and a healthy lifestyle; assist with preparation for death, such as child care; and assist the family to deal with loss. The counselling includes pre-test, post-test and ongoing counselling until death.

Palliative care is comprehensive care of people with active progressive far-advanced disease, for whom the prognosis is limited and the focus of care is the quality of life (Doyle in Uys 2003:8). The patient is assisted with aspects such as hygiene, wound care, or symptom control, and the aim of palliative care is to make patients more comfortable, improve their health, and lighten the family caregivers' load of caring.

It is fairly easy to describe what support should be offered to HIV/AIDS-affected people, but the challenge is for one to come into actual contact with these people. "In order for AIDS ministries to be initiated and to mature, contact with affected individuals needs to be maintained" (Shelp and Sunderland 1987:105). This distinctive aspect of AIDS ministry or care should bear the nature of loving care offered by God's people. The church's healing presence demonstrates God's compassion and concern for all people who are burdened as a consequence of HIV/AIDS. Thus, HIV/AIDS home-based pastoral care among the despairing poor should be supportive, compassionate, consoling and reconciling. In a nutshell, the church should clothe or embody Christ. It should portray the kingdom of God. Such compassion will mediate God to those who are lost and despairing about love and care in the AIDS scourge.

~ ***Identifying points of consideration for home-based care implementation:*** Beginning home-based care, however, requires critical self-evaluation. As already mentioned, this is demanding and challenging and it requires commitment. Referring to starting an HIV/AIDS ministry, Shelp and Sunderland (1987:94) suggest points of consideration:

- ⌘ Firstly, it requires courage. Parishioners may be opposed to the idea (but one needs differentiation - Chapter 4). And, as HIV/AIDS affected people become part of the church, the opposition may intensify (as seen in Rev. Xapile's case in Gugulethu). In fact there could be threats to secede. However, starting a pastoral ministry with home-based care where people are only visited in the homes and not part of the larger congregational family would imply semi-acceptance. The acceptance should be total. As many infected people seek shelter and hope among believers, more and more people would disclose their status.
- ⌘ Secondly, home-based care requires an assessment of how comfortable one is with illness. HIV/AIDS care may mean constantly seeing people dying. The idea of seeing a person deteriorating and eventually dying would be unbearable to others. While love and compassion are crucial for caring for HIV/AIDS-affected people, the ability to render quality care and support should be the determining factor because of the complexities of the condition, such as the stigma associated with HIV/AIDS.
- ⌘ Thirdly, there must be self-examination of one's willingness to be exposed to HIV/AIDS settings and lifestyles. HIV care entails entering into the infected people's experiences, learning about them, loving them and sharing their grief. This certainly is a huge challenge as one tries to dispel stereotypes and prejudices about HIV/AIDS-affected people.
- ⌘ Fourthly, one must contend with one's capacity to separate compassion from condoning the conduct by which a person was infected with HIV. Compassion is a Christian calling and should be practised unconditionally. All human beings should be objects of Christian love, because they were created in the image of God.
- ⌘ Fifthly, one must examine oneself to see whether one is committed to the task. To build a counselling relationship and later forsake a person is severely painful and traumatic for such a patient. The people involved in home-based care should be serious and committed to the task.
- ⌘ Lastly, there should be self-examination about the extent of one's availability. It is pointless to indicate willingness to do home visits, yet hardly have the time to do so.

Parishioners who feel called, and are committed to initiate a home-based pastoral care ministry, should be supported. **Identify and train** (equip) them for this challenging task, then they should be ready to face the concomitant challenges.

Organisation of home-based pastoral care requires the following: establish a dedicated team to lead caregivers, set up a system, find resources, establish support groups and do research (Uys 2003:8). Although Uys writes from a non-Christian perspective, her proposal is valuable.

A dedicated leading team is crucial for successful home-based care ministry. The challenges and demands of HIV/AIDS care might cause others to quit. Therefore, parishioners who are filled with love and compassion and share a vision of being conduits for God's kingdom to HIV/AIDS-affected people should be identified. These people should be trained and supported. Church leadership should provide this crucial role of training, or they should invite external experts to train these people. The training should focus on the disease, the study of high-risk behaviour and reflection on the vulnerable, finite and human condition of mortals (Shelp and Sunderland 1987:113-115).

Cameron (2003:37-43) proposes a comprehensive curriculum of home-based care. This curriculum focuses on four major players in home-based care, i.e. community caregivers, health systems, the persons in need of care, and the community. Cameron's curriculum is well contained, since it exposes caregivers to all role players in home care and where they could possibly receive assistance. Smart (2003:174-181) is right in her stating that in the case of poor people, such networks are immensely valuable in exposing them to their rights, of which they are often ignorant. Therefore, the church should link up with these care-giving players.

~ ***Hurdles in implementing home-based care:*** After identifying and training these dedicated people, home-based care can be implemented. However, among poor people (which is usually the case in African informal and single home-based care), ***finding resources*** is the biggest hurdle. The equipment that is needed, for example bedpans, linen protectors, gloves and towels, are beyond the reach of many. Sliep *et al.* (2001, cited by Uys 2003:10), rightly observe that "People living with HIV/AIDS and their families often live in poverty." It is almost impossible to be involved in home-based care without becoming involved in poverty relief (Zich and Temoshok 1990:201-220; Wardlaw 2000:119-132; Zlotnik 1987:1-7; Uys 2002:10). For food parcels, clothes, assistance with school fees, and other urgent economic needs, it is essential that home-based care be linked with social welfare and an NGO.

Linking the church with social welfare and other organisations is valuable, but its applicability is problematic. Most African governments are aware of the plight of the poor, but deliberately ignore them. Besides, the government may not have the funds. Hence, it would be wise and commendable for a church starting a home-based pastoral care ministry to link up with an NGO such as Child Care and many others that are doing commendable work to reach suffering poor people. Shelp and Sunderland (1987:110) rightly say that "networks" are the key.

Apart from the challenge of material poverty, Defilippi (2003:170) added “spiritual poverty,” which religion can address. Therefore, spiritual poverty is the special area of pastoral care and counselling when, to bring hope, the counsellor communicates God’s healing grace through the historical events of the incarnation, death (crucifixion) and resurrection of Jesus Christ.

- ≈ ***Strategies in implementing home-based care:*** Defilippi (2003:166-171) lists possible strategies that could be adopted in attempting to address poverty. She suggests increased access to social grants, increased self-reliance with regard to food, advocacy and lobbying and linking HIV/AIDS service provision to job creation. Defilippi’s suggestions hold water, but most of them also fail as regards applicability. Very few African governments in the SADC, with the possible exception of Botswana, South Africa and Namibia (at a lower level), have reasonable social grants that can truly address people’s needs. Furthermore, job creation remains a matter of lip service by politicians to obtain poor people’s votes, but implementation has been taking place at a snail’s pace, if at all. Advocacy and lobbying could possibly be the best way to make defiant governments at least heed the plight of the poor. At times this may entail directing the affected people to government offices or agencies where they can be assisted.
- ≈ ***Focus of the home-based care ministry:*** Thus far it has been argued that starting home-based care is a challenge. The care, however, focuses on the infected people, the affected family and the children who will be orphans. Planning for orphans is a challenge that also deserves thorough discussion and planning, but this will not be discussed here. However, support groups within the community should focus also on the orphans. Starting support groups in Africa is relatively easy because of Africans’ general networks, and the church should use this cultural advantage (as discussed earlier). The church should always be the nucleus of support for all people in the home-caring support ministry through what Moltmann (1993) calls “grassroots communities”. Bremridge and Blom (2003:84) listed the functions of HIV/AIDS support groups as sharing life experiences, learning new ways, relaxation and enjoyment, and gratifying interpersonal relationships. But over and above all of these, church/congregational support remains uniquely the oasis of true Christian hope. In home-based care God’s faithfulness to humankind is evident in the person of Jesus Christ, and the community of faith (congregation/church) fosters and nurtures resurrection hope, thereby bringing healing to people living with HIV/AIDS, who are despairing.

### 6.7.3 Home-based pastoral care and the counselling ministry in Africa: basic guidelines

Pastoral care and counselling ministry in Africa, especially to the poor communities, is not very structured. “Structure” refers to well-defined duties/responsibilities at specific times. The poor, the majority of whom are uneducated and least exposed to Westernisation, operate very much on an often referred to “African concept of time”, meaning a clock does not control the individual’s activities, but the “event.” The pastor should design his/her model with this in mind. The stages below may not necessarily be sequential, but they should be noted and followed.

- ☞ Firstly, in designing the HIV/AIDS ministry model, it would be necessary to compile a church **membership inventory**, if it were not already in existence. Church inventory refers to listing members’ specific skills and areas of specialisation that can be useful in the church, e.g. a member who is a social worker can be very instrumental in initiating a home-based care ministry.

However, even though the people are poor, there will be some people who have special skills, knowledge, or are involved in the helping professions. When a staff inventory is done and the members with special skills are noted for their spiritual maturity, the people, together with the pastor, should initiate the ministry. If it is in a rural environment, there are people known for caring abilities in that community who are in the church (this strengthens the case for a bottom-up approach). They should be utilised. These people should be dispersed to cover the congregation’s catchments area. These people would also form the HIV/AIDS caring leadership. They should keep their eyes open and to the ground to see and hear where there is need (i.e. the needy in informal home-based care through community strategies discussed earlier). Furthermore, they should provide care to caregivers in the church.

- ☞ Secondly, the pastor should ensure that he/she networks with NGOs and other organisations that are already working in the area. Because of the nature of the HIV/AIDS disease (i.e. discrimination and stigmatisation), the **people who are involved in caring and counselling should be trained**. Standard training information is contained in minimum standard documents of the Department of Health, SA. As Greyling, Ackerman, and many others say, accurate HIV/AIDS education is crucial to people who will be caregivers. In fact, all HIV/AIDS caregivers should try to keep abreast of the latest information, although it may be difficult to do so in disadvantaged communities.
- ☞ Third is sensitising compassion and in-depth training. The context of pastoral counselling is the community of faith (the congregation), as Louw,



Crabb and Clinebell stated. All believers are responsible for caring for those in need. Crabb suggests three levels of pastoral counselling in the context of a faith community. The first level is the whole community, as all believers show *agape* love and compassion to one another. This certainly is crucial to HIV/AIDS care, where the infected people need acceptance by the community when they come into the church. The second level is the selected church leaders or elders, who should be trained at a more profound level. These people should function as resources and ears for the larger congregation. The third level is for the complicated, most profound and sensitive counselling issues, which requires in-depth training. Furthermore, in HIV/AIDS pastoral counselling, the pastor should be thoroughly knowledgeable about HIV/AIDS issues and their profound theological or Christian implications.

- ✎ Fourth is identifying leaders. In African contexts people in leadership are highly respected and they should be mature (i.e. counselling is usually guidance from elders). Although some pastors may try to instil into their members the fact that they themselves are servants, they are often treated with very high respect. This phenomenon results from the hierarchical nature of African culture. The high respect that the pastor enjoys and the confidentiality that HIV/AIDS counselling requires, poses a huge challenge to the pastor. Although there may be leaders of HIV/AIDS ministry, it should be noted that many people might prefer to confide in the pastor, especially during the early days of infection. Because of this challenge, African pastors should be well equipped regarding HIV/AIDS counselling issues, more than anyone else in the congregation. And, in turn, they should equip the parishioners. Over and above HIV/AIDS education, the pastors should be able to assess people's spirituality in order to encourage spiritual growth and faith development amid the HIV/AIDS scourge, which is the goal of pastoral counselling. The table on African diagnosis (Chapter 5) above can be a valuable resource.
- ✎ Fifth is understanding one's identity as caregiver. The being functions of the pastor are more important than his/her knowing function in Africa;<sup>3</sup> this cannot be over-emphasised in HIV/AIDS care and counselling. Because of the close links and networks that Africans maintain, especially among the poor, who have little exposure to Western individualism, the value of the pastor's care is immense. The community should view the pastor as

<sup>3</sup> Disclosure of HIV/AIDS-infected people does not happen automatically. Stanley Nkosi, who is an AIDS counsellor, tells a story of how his daughter took a very long time to disclose her status to him. She only disclosed shortly before her death (Mark Decker AIDS associates). *Living Openly* magazine also contains painful stories of people who disclosed their status to the pastor. One of the people states, "The other thing that is critically important on the flipside of the disclosure coin is acceptance. We need to do a lot of work in preparing our society and communities to accept people once they disclose" (Peter Busse) (*Living Openly*, February 2000:55).

reliable, dependable and having the community's interests at heart. If they view him thus, they will be more open to him. HIV/AIDS care and counselling is a long and complicated process of relationship building. Eventually, when the pastor breaks through in relationships, the people will accept him. When he is accepted in the homes, then communication of the message of hope begins. But this role is not for only the pastor, but also for all parishioners.

- ✧ Sixth is relationship building. Relationship building should take place by participating in the important functions of people. The pastor should be aware that in poor African communities he/she is often viewed as part of the elite. So associating with the people would break through such barriers. Thus, when an HIV/AIDS incident occurs, the people would approach him with confidence. Alluding to the proximity of the pastor, Clinebell (1984) says that the pastor is in a uniquely advantageous position regarding caring for the people, because he/she observes them daily and interacts with them. This should be the same with all church members; they should utilise their daily relationships and contacts to mediate God's healing grace.

In summary, care for HIV/AIDS-affected people is the responsibility of all believers. The people should be equipped for this ministry (Eph 4:12ff) by the church leadership. HIV/AIDS-infected people who make their status known to the faith community should be loved and accepted unconditionally. People who live and care for people living with HIV in the homes should be noted and supported, and HIV/AIDS-affected people who are isolated and looking for love and belonging should be embraced. People should accept this challenge of showing love and compassion. While all people offer care in the homes, the pastor remains unique as a representative of God's covenant and love during the counselling encounter. Those who do not have food should be put in touch with people or NGOs where they can receive provisions.

However, the question we may ask now is: what are the possible ways of responding to each stage of the HIV/AIDS development during home-based care? How can the HIV/AIDS person be guided to maturity?

#### **6.7.4 Guidelines for pastoral direction in a home-based care model**

##### *6.7.4.1 Counselling and the different progressive stages of HIV/AIDS*

When people are diagnosed as HIV positive, the HIV progresses through different stages. The people providing home-based care should be informed on the appropriate pastoral response, since the person undergoes different crises. The HIV-positive person experiences psychosocial, spiritual, socio-economic and emotional needs. These needs differ at each progression stage (i.e. sero-

conversion/diagnosis, asymptomatic phase, symptomatic phase, serious illness, terminal and grieving). Therefore the pastor and the congregation members who are providing home-based care should be aware of the appropriate response at each stage of the progression<sup>4</sup>.

Progression stage	Counselling focal issues		Pastoral counselling response
Diagnosis/ sero-conversion	When a person is diagnosed HIV positive there is shock that often leads to <b>denial, anxiety, fear and suicidal behaviour or thinking.</b>	<b>Denial</b> - At the breaking of the news, it is a defence mechanism to temporarily reduce emotional stress. Denial gives a breathing space, but if it continues it hampers positive living.	When the person is at this stage, not much talking should be done. Presence with the person is necessary, but if the denial persists it should be confronted so that the person may accept the reality and live positively. The counsellor should be empathetic, assure God's love, trust and commitment to support the person.
		<b>Anxiety</b> - Uncertainty of the progress of the HIV infection, the risk of infection with other diseases, fear of dying in pain, inability to change things, etc. create anxiety.	Correct information should be communicated to the person. Counselling of the person to accept the situation and progress with life is vital. Focus on life in Christ is the controlling factor.
		<b>Fear</b> - HIV-infected people have experienced the pain and death of loved ones by AIDS, so they fear what awaits them, or they fear because they lack knowledge of how one can live with AIDS.	The person should be educated about the facts and information regarding HIV/AIDS. The Christian hope of resurrection should be shared with the person. Death is not the end for a Christian.
		<b>Suicidal behaviour or thinking</b> - Self-blame, knowing that one is living on borrowed time, shame, and fear of losing control of one's life may lead the person to commit suicide.	The pastor should be aware that there is a high risk of suicide in HIV-infected people, especially when they have just been told that they are HIV-positive. More time should be spent with the person.

<sup>4</sup> Hannes van der Walt (2004:33-38) has useful guidelines on how churches and congregations can be involved with HIV/AIDS-infected people at each stage.

Asymptomatic phase	<p>At this stage the person appears healthy like other people, though he/she carries the HI virus. The person may have emotional ups and downs as he/she remembers that he/she is carrying an HI virus. This person needs normal living guidance and continuous support. There could be a danger of obsessive conditions and hypochondria as the person becomes so preoccupied with the smallest physical changes or sensations, and this causes obsessive behaviour or hypochondria (Van Dyk).</p>		<p>The counsellor should always be available when the person needs him/her. Counsellor should strengthen the person's faith and relationships in preparation for the later terminal stage. To avoid obsessive behaviour or hypochondria, the person should be encouraged to accept the HIV-positive status, which would lessen this phenomenon as the person adjusts to cope with the situation. The correct information should be communicated.</p>
Symptomatic phase	<p>The HIV/AIDS-infected person at this stage feels emotionally <b>isolated, loneliness and mourning, sense of loss, guilt, anger, grief and socio-economically deprived.</b></p>	<p><b>Isolation and loneliness-</b> HIV-infected people's self-esteem is threatened as friends abandon them, leaving them feeling unworthy. The inability to continue in a career or having children also contributes. The person needs contact with others.</p>	<p>Emphasize human worthiness as defined by a relationship with Christ, not material or profession. The person should be encouraged to feel self-sufficient in Christ. The faith community should come alongside for comfort, which makes <i>koinonia</i> care crucial. The person should be accepted in the community to belong and get healing.</p>
		<p><b>Mourning and sense of loss</b> - Often, HIV people experience a loss of their hopes, dreams, sexual relations, independence, and importantly, loss of life and many other things.</p>	<p>The counsellor should experience a process of grief with them. Be patient and show compassion and encourage the celebration of life. Encourage wholeness through union with Christ.</p>
		<p><b>Guilt</b> - Guilt may be intense for someone who has contracted the disease through promiscuity. One feels guilt about the wrong choices of a sexual partner. He/she feels guilt that he/she has let down the family, friends, relatives, etc.</p>	<p>The pastor should be supportive and dispel the guilt. The person should be helped to realize that the circumstances of HIV infection are not the problem. He/she should be aware of a gracious God who accepts and forgives the guilt through his great love in Christ. The pastor should encourage reconciliation with God and other people, where possible.</p>

		<b>Anger</b> - HIV people are often angry with themselves for being irresponsible; angry with people who infected them; angry that there is no cure; angry at society's reaction of hostility and indifference.	The pastor's warmth and love often soothes the anger as the person realizes that there are people with his/her interest at heart. Acceptance of the person plays a vital role.
		<b>Grief</b> - Grief is more like loss. If the person is a parent he/she grieves for the children who will remain behind.	The art of listening is critical as the person grieves for loss. The pastor's presence is important, although he may be silent.
		<b>Socio economically deprived</b> - Some companies dismiss workers when they are diagnosed HIV-positive, though this is illegal. Therefore, loss of employment, social discrimination and stigma, and the need to buy anti-retroviral medication drain the HIV person's financial resources.	Social support through the community of faith ( <i>koinonia</i> ) should be encouraged. Where possible, food parcels and financial assistance should be provided to the person.
Serious illness	The person may have serious depression. The feeling that he/she has lost much in life, feeling of powerlessness and knowing that many have died of AIDS and they will die, cause their depression. They may also experience self-rejection, hopelessness and worthlessness. These people need value, respect and dignity.		The counsellor should encourage the celebration of life. Resurrection hope as the final destiny should be emphasized. Hope and meaning as found in Christ should be emphasized.
Terminal	The people at this stage are fragile, uncertain and in extreme fear. The people need peace, acceptance and security for those left behind especially children. These people are confronted with death and loneliness. They ask spiritual questions about death, sin, guilt, forgiveness and reconciliation. They ask the theodicy question: Why does God allow HIV/AIDS and death?		God's unconditional forgiveness of sin and guilt, and reconciliation in Christ should be shared. Resurrection hope should be emphasized. The counsellor should assist with succession planning and be with the person through the process of dying. The counsellor should be aware of Kubler Ross's stages of the dying (denial, anger, bargaining, depression, acceptance, and resignation). Eschatological hope should always be emphasized.

Grieving	Grief counselling normally is focused on family members who were the caregivers who witnessed their loved one dying. There is depression, sadness, feeling of loneliness and abandonment, etc. They mourn the loss	Since the pastor/counsellor would have been involved with the family for a long time over the period that the HIV/AIDS person was still alive, it becomes easier to encourage peace with what has happened. The counsellor should always minister by his presence even in silence. But it is important to encourage people to go on with life.
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In addition to pastoral care and counselling on response guidelines at each stage, it is important to be aware of the stages that a person living with HIV/AIDS person undergoes from diagnosis until he/she has accepted the status and starts ministering to others, i.e. spiritual growth in the situation, which is the goal of Christian counselling.

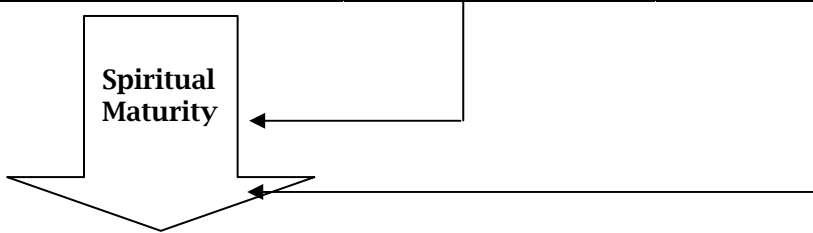
#### 6.7.4.2 HIV/AIDS counselling: maturity and the spiritual dimension

A well-counselled person should be a resource to the community of faith and should be active in bringing healing to other people, as a model of Christian therapy. Kubler Ross (1987:11) observed and commented: "Of all the thousands of patients I have seen literally all over the world, I have never seen such mutual support and solidarity as I have among AIDS patients themselves and their partners".

The table below therefore shows (in three models in juxtaposition) how a person becomes spiritually mature in the context of the Christian community and then be a resource to other HIV/AIDS affected people both in the congregation and outside.

Louw's stage model	Van Dyk's (Attachment theory - tasks of mourning)	Jackson's stages of mourning
1. The impact stage (shock, denial, severe anxiety and helplessness)	Task 1. To accept the reality of the loss.	1. Shock
		2. Denial
		3. Anger
2. The regression stage (forced to deal with reality of the situation)	Task 2. To experience the pain of grief.	4. Bargaining
		5. Guilt
		6. Depression

3. The internalization stage (mourning period and process of acceptance and acknowledgment of the reality)	Task 3. To adjust to a changed environment.	7. Acceptance - recognizing that the situation cannot be changed.
4. The reconstruction stage (decision-making, future planning and target development, discovery of self-worth and courage to make new decisions, reaching out to others, witnessing the grace of God).	Task 4. Withdrawing emotional energy and reinvesting in another person, or field of life.	8. Coping - adjusting to a new life situation and regaining hope.



The reconstruction, coping and reinvesting stages denote the final stage of the healing process (and maturity). Spiritual maturity in Scripture is a corporate identity (*koinonia* concept). Growth is growth in mutual fellowship and outreach. Members of the body are urged to develop and become mature (corporately) attaining to the whole measure of Christ (Ephesians 4:12-13). The full measure (growth) in Christ manifests through the quality of *koinonia* care whereby HIV/AIDS affected people are accepted, embraced and encouraged. From the disclosure of the HIV-positive status, the faith community (*koinonia*) walks the painful journey with the affected person(s) until the recovery stage. Thus maturity and healing do not necessarily only occur through the individual's inner potential, but through community acceptance, support and encouragement.

## 6.7 Preliminary Conclusion

This chapter has suggested a model design for HIV/AIDS home-based care congregational ministry. It argued that the congregation members should actively participate in the lives of poor and HIV/AIDS affected people, thereby providing support and healing.

It emerged from the discussion that:

- ≈ The home-based care concept basically refers to care that is provided to HIV/AIDS affected people at home by family, friends, relatives and the community. This therefore allows the HIV/AIDS person to stay at home and

to be cared for as comfortably as possible, even to the point of death. Home-based care is a cheaper way of caring for the sick than hospital care. In Africa, where health care facilities are scarce and the people are poor, it is the model that can be practically adopted.

- ≈ Home-based care formally originated/emerged in USA in 1986 with the Committee on a National Strategy for AIDS (CNSA), but in Africa family care has always been part of normal life, though it was not formalised. However, as a formal structure, home-based care is done in three ways (three models), according to Uys: integrated home-based care, single service home-based care and informal home-based care. Integrated home-based care links the service providers (medical) and families. It is the most effective model. But in Africa it is largely inapplicable because of scarce health-care resources.

***Single service home-based care*** is provided by single service component, e.g. hospital, NGO or church. But since churches are the most strategically located institutions in Africa and are in touch with people on the ground (grassroots level), they should play a leading role in providing single service home-based care. But the church home-based care should be linked to NGO working in the areas in order to address poverty as well. ***Therefore the model of congregational home-based care proposed in this chapter is single service home-based care, but it should be linked to informal home-based care.*** Informal home-based care refers to family members who care for people living with HIV/AIDS in the home with little or no external support and assistance. The majority of HIV/AIDS care in Africa falls into this category, hence organisations that may provide single service home-based care within an area like the church, which is being advocated, should identify informal home-care providers and support them.

However, though informal home-based care is the common paradigm in Africa, it fails to address the twin challenges of HIV/AIDS and poverty. Single service home-based care (congregation), which is a recognisable institution, can/should be used as a channel and link between agencies that provide material resources and informal home-based care providers who may be overlooked in the community.

- ≈ Since in Africa churches are strategically located, they should provide home-based care to HIV/AIDS affected people, i.e. single service home-based care. In providing home-based care, the church translates (embodies) God's kingdom into reality. Congregations can provide home-based care support system by designing an HIV/AIDS home-based care ministry. Church leadership should identify members who have the interest and skill to steer the ministry. However, though there could be challenges in the process, love (*agape*) for the HIV/AIDS affected should energise them.



Furthermore, since many communities affected by HIV/AIDS are poor, caregivers should network with community structures (NGOs or government welfare) to mobilise material resources for the needy. Thus the *paraklesis* is crucial for advocacy and comfort.

- ~ The “being” functions of the pastoral caregiver are very important in Africa. The pastor should build a relationship of trust with the community in order for the people to open up about their HIV/AIDS fears, anxieties and despair. The community should view him/her as someone with the people's interests at heart. He/she should participate in some community activities, which helps to destroy the wall between church and community. The pastor and congregation members should keep their eyes to the ground to identify affected people who require support through the following strategies: scope, visibility and invisibility, time line, space tour and weekly routines.
- ~ Lastly pastoral caregivers should be aware of the general psychosocial, spiritual and socio-economic and emotional needs that people living with HIV/AIDS experience at different stages of the progression and the appropriate response.

As people living with HIV/AIDS get home-based pastoral counselling and become hopeful again, they become part of the church ministry team that ministers to other HIV/AIDS-affected people from experience. They become effective exhibits of God's healing grace that strengthens and encourages those despairing in their situation. Thus their practical faith (mature faith) would ignite flames of hope in many other HIV/AIDS-affected people.

Based on the discussions and arguments in Chapters 2 to 6, what conclusions can we come to regarding the issues raised? This question therefore brings us to the end of this research (Chapter 7).

# VII.

## *Summary of Chapters, Findings and Recommendations*

### *7.1 Introduction*

This chapter is in two parts. The first part summarises the arguments of this book and the second part outlines findings and makes recommendations on the issues raised and discussed.

### *7.2 Summary of Arguments*

#### **7.2.1 Chapter 2**

It emerged in the study that in addressing HIV/AIDS in Africa, it is important to start with an African contextual understanding of the HIV/AIDS scenario. A contextual understanding places the naturalistic explanation of HIV/AIDS within the African personalistic worldview of sickness. Therefore, in providing pastoral care one does not only focus on facts and information and Western mode of healing, but engages the African person holistically.

A worldview refers to a way in which people view reality. It consists of basic assumptions, symbols, etc. that provide a more or less coherent, though not necessarily accurate, way of thinking about the world. Thus one's worldview

provides a system of beliefs, which are reflected in his actual values and behaviour. However, while many aspects can be considered under the African worldview, what concerns us is the worldview of sickness that is directly related to HIV/AIDS.

The African worldview of sickness is personalistic. A personalistic medical system is one in which disease is explained as the result of the active purposeful intervention of an agent, who may be human (a witch or sorcerer), non-human (a ghost, an ancestor, an evil spirit), or supernatural (a deity or other very powerful being). The sick person is viewed as a victim, the object of aggression or punishment directed specifically against him. This view of sickness is in contrast to the Western naturalistic system, which explains sickness in impersonal, systemic terms. Disease is thought to stem, not from the machinations of an angry being, but rather from such natural forces or conditions as cold, by an upset in the balance of basic body elements. Thus, supernatural causes are perceived as the causes of sickness in Africa, while in the West they are non-supernatural causes.

The African personalistic causes of sickness result in destabilisation of the equilibrium. Health in Africa (i.e. freedom from sickness) evokes equilibrium. Africans generally believe that human beings are in a state of complete dependence upon the invisible powers and beings. Health is a sign of a correct relationship between the person and the supernatural world, and breaking from the delicate balance causes misfortune and sickness. Thus one could not possibly fall sick unless there is a disturbance within the systematic rhythm of life, which includes: the breakdown of harmony in personal and communal relationships, disrespect for cosmic existence within the cosmology of an African spirituality, and/or lack of adherence to African traditional health values.

However, the personalistic view of sickness and suffering does not negate or diminish the naturalistic cause of sickness such germs, viruses or bacteria. Though most Africans are aware that some illnesses have natural or organic causes, there is still an overriding belief in the supernatural or spiritual causation of illness. Therefore in seeking a cure, one does not rely only on medication (herbs, injection and tablets), but also mystical and spiritual remedies.

HIV is the virus responsible for causing AIDS. This explanation is naturalistically correct. How then is it perceived personalistically/supernaturally? Many African people, especially among the rural poor or least educated, believe that HIV transmission, AIDS and deaths are caused by witchcraft. However, with the magnitude of HIV/AIDS awareness, many people are embracing the naturalistic explanation (though within a personalistic

framework). Many African people agree that witchcraft or ancestors do not directly cause HIV, but they are always associated. For instance:

- ~ A jealous relative may cast a spirit into a successful young professional that blinds him/her, leading to unsafe sex with an HIV-infected partner;
- ~ The ancestors may also be angry with a young successful professional who forsook them and broke the taboos. Hence, they withdrew protection leaving him/her vulnerable by having sex with an HIV-infected partner. Besides, they may also direct him/her to have sex with an HIV-infected person so that he/she may conform to the balance.

Therefore, although the HI virus may be ultimately responsible for causing AIDS, there is always a supernatural link. More than 25% of people in Yamba's study in Zambia asked a question that clearly reflects this thinking. They argue, "Why else will one man become infected and the other remain uninfected when both have had sex with the same woman?" (Van Dyk 2001:114).

The association of HIV/AIDS with supernatural causes has a crucial psychological function. If one blames external factors such as witches, sorcerers for AIDS, it removes the responsibility from the HIV victim, family and society. In addition, this hypothesis fits well as a comprehensive explanation within the African worldview of sickness, thereby removing feelings of guilt and anxiety. The witchcraft beliefs also resolve the community's need to explain why some people who are at risk do not contract HIV. Furthermore, because of HIV stigmatisation, attributing HIV/AIDS to witchcraft helps the family not to be stigmatised by the community.

However, attributing HIV to supernatural causes has negative implications. The belief that every sickness or HIV is caused by an external, supernatural beings implies that individuals cannot be held responsible and accountable for their own behaviour. HIV calls for responsible sexual behaviour.

The African worldview should be taken seriously if one is to effectively minister to them (i.e. pastoral care). Thus the perception that sickness is caused or always linked to supernatural causes must be acknowledged. Mbiti (1975:3) is right that, unless Christianity fully occupies the whole person as much as, is not more than, traditional religions do, most converts will continue revert to their old beliefs and practices for perhaps six days a week, and certainly in times of crisis and emergency.

However, focusing on naturalistic explanations of HIV/AIDS in terms of facts and information, it is important for caregivers to distinguish clearly between HIV and AIDS. HIV refers to the virus that depletes immunity (the body's defence system) and makes the body vulnerable to invasion by pathogens. When the body cannot defend itself, which means that any pathogen can enter with little or no resistance, then one talks about an AIDS condition. From being

diagnosed HIV-positive to full-blown AIDS and death can take 8-10 years, but with antiretroviral drugs and positive living, it may take far longer than this. The distinction between HIV and AIDS allows counsellors to make HIV-positive people hopeful from the moment of diagnosis by making them aware that being HIV positive is not a death sentence. There are still many years to be lived.

Regarding the origin of HIV, the conclusive fact backed by scientific research is that there are two HIV strains, HIV-1 and HIV-2. HIV-1, which is more virulent and has spread throughout the world, originated in a chimpanzee sub-species. A particular kind of chimpanzee is known to carry a virus quite similar in structure to the HIV. The HIV-2, which is less virulent, is found in West Africa and originated from the sooty mangabey monkey (Christian AIDS Bureau 5.2/16). Once the HI virus had entered the human bloodstream, the rapid spread of the HI virus globally was largely the result of international travel, the blood industry and drug use.

Regarding HIV/AIDS infection and spread, it is important to note that though semen, vaginal fluid, milk and blood have a high HIV concentration, which makes transmission possible, there are other conditions that should be met, i.e. human body temperature, moist environment, no contact with atmosphere, and right PH. The other risk-increasing factors are entry point (opening or cut), sexually transmitted infections, and quantity of virus.

Statistically, 70% of the HIV/AIDS cases are in sub-Saharan Africa. The reasons for the extensive epidemic are not very clear, but it seems the most convincing explanation is a combination of those of by Hunter and the Christian AIDS Bureau as well as other environmental factors, usually cited by many writers including Jackson and Louw (see Chapter 2). Hunter (2001:12) stated that a number of factors are at work in determining HIV prevalence, including factors particular to the HIV-1 virus itself and factors in the human environment in which it finds itself. There is some support for the theory that different clades, or genetic subtypes, of HIV-1 are less virulent than others. The predominant subtype in Uganda may not be as virulent as those found in other countries. Clad B, associated with epidemics in the Northern Hemisphere, may be less virulent than all clades found in developing countries. The Christian AIDS Bureau (3.3/1) states that part of the reason why HIV statistics are so high in Africa is that the virus has been present far longer in the communities of Africa. The virus originated in Africa and then spread to other continents, as transport became more freely available and travelling became easier. This is only part of the reason, as infrastructure, migrant labour, poverty, culture, etc. also play a major role in extent of the spread of the virus.

Therefore, Hunter's explanation of different clades and genotypes (i.e. "some researchers hypothesise that African clades are more virulent" Hunter

2001:34), the Christian AIDS Bureau's account of history (origin) and length of HIV presence on the continent, coupled with the environmental factors noted by Jackson, Louw and many others, may be the best comprehensive and convincing explanations for Africa's high HIV/AIDS rates. However, this explanation does not fully account for the factors responsible for the African scenario. More research should be done. But what seem to be fanning the spread in Africa (though not exclusively on the continent), are macro, socio-economic, sexual behaviour and biomedical factors, as indicated.

The African worldview of sickness and how HIV/AIDS fits into this framework coupled with naturalistic explanations, therefore, forms the core information for meaningful and appropriate pastoral care. Failure to recognise the centrality of the African worldview means the counsellor misses the crucial element of African healing, while at the same time scientific explanations also provide vital information for informed care giving at each level of the infection.

### 7.2.2 Chapter 3

Poverty is a difficult concept to define clearly. But it can be defined in terms of basic needs, which are those things that an individual must have in order to survive as a human being. These needs include clean air and water, adequate and balanced food, physical and emotional security, physical and mental rest, and culturally and climatically appropriate clothing and shelter. However, the human race does not depend on the survival of a single individual, but on the survival of communities, hence the individual needs should include those of the community. These community needs are defined as: sexual regeneration, a system of communication, a belief and educational system for cultural continuity, physical and cultural security, a political system defining leadership and decision making, and systems of health and recreation for maintaining the wellbeing of sufficient numbers to maintain the community.

Poverty can refer to case poverty, community poverty, absolute poverty and relative poverty. *Relative poverty* refers to people whose basic needs are met, but who still experience some disadvantages regarding their social environment. *Absolute poverty* refers to the inability of an individual, community or nation to meet its basic needs satisfactorily. *Community poverty* refers to a situation where almost all are poor and where the more affluent people are more visible to the rest of the people living close to them, as seen commonly in rural areas. *Case poverty* is found in affluent societies, where individuals in a family suffer and where individuals do not share in the general wellbeing of society.

Poverty is determined, firstly, by measuring the Gross National Product (GNP), i.e. the total value of a nation's annual output of goods and services, thereby classifying countries as low-, middle- or high-income countries. Secondly, it is

determined by the Physical Quality of Life Index (PQLI), i.e. the state of people's health and welfare and the standard factors are: life expectancy, child mortality and adult literacy. Thirdly, it is measured by means of the Basic Needs Approach (BNA), in which the presence or absence of minimal basic human requirements for life, as well as essential services, indicate the degree of poverty, or the level of standard of living. The basic requirements are: adequate food, safe drinking water, suitable shelter and clothing, as well as basic household equipment; and the services measured are: sanitation, public transport, health and educational facilities.

However, of all the poverty measuring approaches, none can completely identify and quantify poverty. Though poverty is commonly discussed, it is interesting to note that first and third world poverty are different. Poverty in the first world is usually relative and respective governments address it through welfare, while in the third world the poor actually struggle to get their daily food. Particularly in Southern Africa, poverty means not knowing where the next meal is coming from, or fearing eviction from their meagre dwellings because they cannot pay the basic rental. There is also fear that the breadwinner will lose his job.

Therefore, it is important to emphasise that, though there are poverty indicators, one should be warned about the possible dangers of such global indicators. If the income indicators are employed in many rural communities, very few or none would be above the poverty line in countries like Zimbabwe, Mozambique or Malawi (just to mention a few). But these communities would be clear among themselves about who are the needy in their regions. In such situations it would be unwise to stick rigidly to global indicators, since none would care for and assist the other. In fact, in many cases in Africa relative poverty may be the best way to measure poverty and to mobilise interventions. Communities are aware of the orphans and needy widows among them who require handouts. Thus poverty is contextual and experiential. Pastoral caregivers in poor communities should be sensitive to this fact. The community should define their poor and then jointly intervene.

Poverty in the Bible (Old Testament) denotes (1) lack of economic resources and material goods; and (2) political and legal powerlessness and oppression. And it is denoted by the words *'ebyon*, *dal*, *mahsor*, *miskin*, *ras*, *'ani* and *'anawim*. These various Hebrew words for poverty don't mean much apart from their context. Therefore, an etymological approach to the study of these words should be discouraged, but context and usage in understanding the term should be encouraged.

Nonetheless, while it is difficult to represent the various "poverty concepts" denoted by the Hebrew words in their contexts and usages, there is an insightful trend that can be adopted. Old Testament traditions emphasise

different aspects. The legal texts regulate the treatment of the poor, seeking to protect the poor, widows, orphans, or strangers (Lev 19:9; 25:25, 35). The prophets show a concern for those economically exploited (e.g. Isaiah and Amos). The wisdom traditions view poverty from different perspectives. Proverbs sees poverty as one's own fault (e.g. Prov. 6:10-11; 10:4; 13:18), while for Job poverty results from political and economic exploitation (e.g. Job 29:12, 16; 30:25; 31:16). The Psalms present God as the defender of the poor (e.g. Ps 22:26; 35:10). The narrative literature of the Pentateuch and Deuteronomistic history show little interest in the poor, but is concerned more with critiquing kingship.

Thus the various strands of Old Testament traditions have different focal points. The legal, prophetic, wisdom and liturgical traditions all see poverty as a matter of grave significance to the community. The legal and the prophetic traditions present the harsh situations of poverty: hunger and thirst, homelessness, economic exploitation, legal injustices, lack of sufficient farmland. The liturgical tradition (Psalms) presents a God who assists the poor in their distress. In the wisdom tradition, the wise in Proverbs view poverty as either the result of laziness or as representing the judgement of God, but by contrast Job views the poor as victims of economic and legal injustices.

Therefore, the Old Testament in its various descriptions denotes the poor as the needy, who are without power and abused by those with greater power. They (the poor) may also not have the capacity to provide the essentials of life for themselves. Their deficiency in life-supporting power is understood to exist in relation to the rest of the community, which also indicates poverty as contextual and relative.

The concept of poverty in the New Testament derives from two Greek words that are translated "poverty/poor". The words are *ptochos* and *penes*. Just as the words translated as "poverty" in the Old Testament should be understood in their context and usage, the New Testament words should be understood in the same way. *Ptochos* occurs 34 times – 24 times of which in the gospels (and mostly in Luke). In the gospels *ptochos* is used in various ways, e.g. the literal sense (Matt. 10:21; cf. Luk. 18:22) and in a spiritual sense in Matthew (5:3). However, what is apparent about the word "poverty" is that it generally designates a person(s) and group(s) lacking (totally or in some degree) the necessities of life: food, drink, clothing, shelter, health, land/employment, freedom, dignity and honour, etc. (cf. Job 24:1-12) (Hanks 1992:415). Furthermore, it is also clear that some kind of option for the poor is represented in most New Testament literature (e.g. Luke).

Therefore, what emerged from the discussion on poverty is that it is experiential, contextual and relative. The experience of their condition among the poor is an important indicator to reveal poverty. Secondly, the people in



the community are aware of the poor people around them, though organisations may use global indicators. Thus poverty is relative. These communities share a common idea of poor people designated as needy, without power, abused by those in power, and lacking the necessities of life (e.g. Job 24:1-12). Poverty is not an abstract concept. It is conspicuous to people in whatever context they are. They see, feel and experience it. Therefore, whether by rules, principles, paradigms or symbols, the Scriptures instruct the privileged to care for the less privileged.

Poverty in biblical times was sometimes caused by natural disasters, oppression (e.g. in Prophets) or laziness (e.g. in Proverbs). But in our time there are many other factors, including HIV/AIDS. Poverty promotes the spread of HIV/AIDS and in turn HIV/AIDS advances poverty. However, though it is a fact that there is a link between HIV/AIDS and poverty, the interactions are myriad, complex and not fully understood. HIV infection is not confined to the poorest, even though the poor account absolutely for most of those infected. Thus the relationship between poverty and HIV transmission is not simple. If it were, South Africa might not have the epidemic on the largest scale in Africa, because South Africa is rich by African standards. Botswana is also rich, but has the highest levels of infection in the world (at the time of this publication). Thus, while most people with HIV are poor, many others are infected.

However, the apparent connection between these two issues (i.e. poverty and HIV/AIDS) works in two directions. Poverty increases vulnerability to HIV infection and plunges the family into deeper poverty, and HIV/AIDS exacerbates poverty as the potentially productive person becomes powerless and draws from his/her savings. Consequently, poverty trickles down to the whole family. Therefore in simple terms there is a twofold answer to the question: how does poverty increase/causes HIV/AIDS?. Firstly, poverty increases poor people's vulnerability to HIV/AIDS (i.e. poverty is a push factor). It leaves poor people with little or no alternative but to indulge in risky HIV/AIDS activities. Secondly, it accelerates immunity depletion due to poor nutrition (i.e. the poor infected person dies sooner). The answer to the question: how does HIV/AIDS cause poverty? is: HIV/AIDS causes poverty through, firstly, draining households resources (income and many other resources and loss of employment) by increasing health and funeral expenditures, which may lead to selling of assets such as land, livestock or goods such as a car to cover expenses. Furthermore there is loss of subsistence labour. Secondly, consumption on family spending (e.g. food and general upkeep) in HIV/AIDS-affected households declines significantly, while medical care rises. Thirdly orphans are less likely to attend school (or at least get quality education), hence they are unlikely to be employed and so in turn become vulnerable to seduction and infection, becoming the poor of the succeeding generation (poverty culture).

However, importantly, though there is apparently a clear relationship between poverty and HIV/AIDS, a simplistic approach should be avoided. As pointed out earlier, the interactions are myriad, complex and not fully understood. Therefore, one is encouraged always to do a contextual analysis to determine the specific factors responsible for fanning HIV/AIDS in a particular situation before intervention.

### 7.2.3 Chapter 4

Christians' social involvement should always have a sound theoretical basis. The foundation of Christian action/praxis is always theory (Scripture). The faith community (*koinonia*) has the responsibility to translate doctrine/Scripture to real-life situations so that the wider community may see. The concretisation of Scripture is made possible through the Holy Spirit's agogic function that enlivens the *diakonic* functions of the *koinonia*. Thus practical theology is a theological reflection and construction arising out and giving to a community of faith in the praxis of its mission. Practical theology is critical and constructive reflection on the praxis of the Christian community's life and work in its various dimensions. Practical theology investigates Scripture and the tradition, on the one hand, and the shape of the ecclesiastical ministry, on the other, for the sake of constructive and critical guidance of the church's praxis. It aims at a kind of knowing that guides being and doing, a critical reflection on the praxis of the Christian community's life and work in its various dimensions, e.g. caring for the poor and HIV/AIDS-affected people.

However, for *koinonia* praxis not to be superficial, the Holy Spirit transforms Christians' lives. A transformed person becomes a pneumatological being who functions within an eschatological perspective. Within this sphere the praxis of God in Scripture that is contextually applied (hermeneutically) is interpreted and translated by the faith community (*koinonia*) to wider community. Practical theology therefore is the hermeneutic of God's encounter with human beings and their world. This encounter results in communicative faith actions. This is the reason why the praxis of the Christian faith and the practice of the church can be an object of research.

The *koinonia* is the carrier and conduit not only of Word but also deed (Word and action). Christians get involved in the lives of the poor and HIV/AIDS-infected people, while at the same time they reflect on the message of the Kingdom. In such a situation there is interaction: theory-praxis and praxis-theory to avoid the pitfalls of making *diakonic* functions an end, instead of the Lord Jesus Christ.

Practical theology as pastoral care (i.e. *koinonia* care) should be the task of all believers to ensure that they get involved in addressing the poverty and the plight of the HIV/AIDS-affected people around them. By getting involved with

people in their situation, Christians would be shifting their position from apathy to empathy and action. The social problem of poverty cannot be addressed meaningfully, if people and society approach suffering people from a position and attitude of apathy. This position also inflicts apathy or frustration on poor people. Therefore, Christians should translate gospel truth to real-life situations (enfleshing the message of the kingdom), which brings hope and healing to people. And this is possible through pastoral care, i.e. *koinonia* care.

*Koinonia* (congregation system) care through adopting a family metaphor is a challenge to care for one another and community members. The church as family (system) metaphor drives a practical theological ecclesiology, which means *koinonia* care would be central. Christians would view themselves as part of a system and they would assist one another as the need arises. Furthermore, the church should move beyond the mutual care of believers to the wider society as an exhibit of God's kingdom. However, it is important also to underline that Christians' social action should always be backed by sound and serious theory or reflection. Christian conduct or action/praxis should be in line with Scripture. The faith community (*koinonia*) has the responsibility to translate doctrine or Scripture to real-life situations so that the wider community may see. The concretisation of Scripture is made possible through the Holy Spirit's agogic function. Thus all transformed people who are part of the church should strive to enflesh God's kingdom, so that they attract other people and extend God's kingdom, which is always the end of Christian service.

Thus it has been argued that for the Church to be practical within the HIV/AIDS situation, it should be driven by the family (system) metaphor. Systems theory views each believer as being part of a whole with interrelationship and interdependence with others and exerts a *diakonic* challenge. The Church (faith community - *koinonia*) is challenged to care for its members (mutual care). Believers identify with one another and share their burdens. The caring extends further to those who are outside. Therefore, for the Church to be able to respond to the HIV/AIDS pandemic, it should adopt a systemic ecclesiological approach driven by the family metaphor, which promotes home (family) caring.

However, the systems approach is not alien to Africa. It is evidence in Scripture and African extended family practices. We can be informed from these two systems in our ecclesiological design on how we may care for the poor and HIV/AIDS affected people.

The African extended family system is the important structure that has/is providing care support functions in Africa. The system provides healing in times of crisis; assists with practical care (e.g. food handouts and ministry of presence) in sickness and death; provides structure for orphan care, adoptions

and integration when parents die; and numerous other care and support functions. In the Bible, i.e. Old Testament (Jewish caring system), the *bet 'ab*, which is equivalent to the African extended family, was central in providing primary care for the sick and needy members. But within the broad theocratic Jewish system *Yahweh* instituted various laws that governed the day-to-day living of the Israelites. There were laws for child care (fatherless), widows, the sick and aged, care for the poor, etc.

In the New Testament period (Greco-Roman world), though they held to the Jewish family structure, a new concept of family arose. The word family was used metaphorically. The new family is the community of believers, i.e. God's household or family. And the new family of God in the faith made social and ethical demands on *koinonia* (Acts 4 and 5). They were expected to assist one another.

The common feature, however, of the African extended family and biblical family system is selfless service (*diakonia*). The systems reveal this central Christian ethic. Within the family system one does not view oneself in isolation, but as part of a community/family in which you don't only seek to satisfy your interests but also the interests of others. Life is not about "me - I", but about "us". This therefore implies that HIV/AIDS home-based care structures in Africa may easily be erected because of the communal structures that are already in place. Though the structural system requires transformation, there are lessons that the church may learn in order to provide successful care. Christians should not view themselves in isolation but as part of a system, which challenges them to address the interests of others, especially those with HIV/AIDS.

#### 7.1.4 Chapter 5

Pastoral counselling in Africa is the appropriate approach that can satisfactorily and meaningfully deal with the plight of HIV/AIDS-affected people. The care and counselling is not only provided by the professional pastor but also by the faith community (*koinonia*), from the time a person is diagnosed HIV positive until death. Thus *cura animarum*, which is a classical formulation of pastoral work, denotes a special process of caring for human life because God created human beings and they belong to Him; it is a congregational task. Therefore within this paradigm the Christian community would view itself as key and central to providing support and healing to HIV/AIDS-affected people.

Pastoral counselling entails building a *relationship* (counsellor and counselee), where the counsellor *facilitates* the counselee's *growth*. In Africa counselling is equated to divination. The counsellor (diviner) listens and interprets people's stories. The stories that Africans bring to the diviner (i.e. counsellor) are

everyday stories. They are also expressed in everyday language. The stories normally centre on relationships affecting one's clan. The symbols and signs used to express these relationships come also from everyday life situations of the cultural milieu, which makes it crucial to know the African worldview. Furthermore, African counselling often takes the form of advice counselling.

Specifically focusing on HIV/AIDS counselling, it is geared towards facilitating the counsellee's quality of life by helping one to manage problems and cope after the disclosure of the HIV-positive status. However, cultivating hope for a life beyond infection requires a more holistic and promising approach than Rogerian client-centeredness. Pastoral counselling is arguably the most appropriate approach that may be able to deal with the plight of people living with HIV/AIDS. A person living with HIV/AIDS faces death and he/she asks questions related to God and soul, life and death, condemnation and forgiveness, etc., and pastoral counselling (therapy) is the discipline that is best equipped to deal with these issues. It meaningfully addresses the issue of death and has ability to instil strong hope and meaning that transcends the present situation and anticipates the ideal.

Pastoral counselling to people living with HIV/AIDS transforms their human existence so that victory over sin and death become a reality which imparts meaning to life. Hence the HIV/AIDS person would live his life beyond infection positively, which is crucial for physical healing also. So, in pastoral counselling, both horizons of hope – immediate (positive living after HIV-positive diagnosis) and future (resurrection hope) – are merged.

HIV/AIDS counselling takes place in two categories, i.e. pre- and post-HIV-test counselling. The pre- test counselling is to find out why individuals want to be tested, the nature or extent of their risk and to prevent further infection. The post-test counselling seeks to erect support structures, if the person is HIV positive, but for the HIV-negative person it educates him/her to live safely thereafter.

When people become HIV infected, however, the theodicy question springs to the forefront. Why me, God? But when Africans ask the why? question they are usually not wrestling with a meaning issue, but asking a question that prompts an instant answer from a diviner or sangoma. In fact, the why? question is preceded by the who? question; Africans want to know “who?” caused the HIV infection first and then “why?” Though they may accept a naturalistic explanation, it is always interpreted within the personalistic (supernatural) framework. Therefore, healing among Africans entails shifting the supernatural worldview (cause and effect) to biblical thinking that does not answer every “why” question. Thus over and above the theological assessment of God images, faith analysis and religious analysis, an African counsellor should be able to determine/diagnose the intensity of African thought patterns

(worldview) in order to offer meaningful, effective and relevant counselling to HIV/AIDS-affected people. At times community (relations network) influence plays a very negative role by exerting pressure on the person to conform to traditional practices that conflict with a pastoral/Christian mode of healing.

Pastoral counselling in Africa, within systemic relationships, should therefore be able to erect support structures for people who may be cut off from their relations network as being deviant because of their Christian convictions. It should be patient with those who oscillate between the two spheres as they count the possible cost of their actions. Thus we should heed Jude's words "Be merciful with those who doubt" (Jude v. 22). Being cut off from traditional support structures entails extreme pain because for Africans "a person is a person because of others". Thus being cut off seems like the end of the world. *Koinonia* care therefore provides crucial support and cushioning in this situation.

A pastoral counsellor should have the following characteristics: non-possessive warmth, empathy, genuineness, listening skills, interpathy, respect, concreteness, confrontation, confidentiality and immediacy. These qualities are applicable in any context, but in addition to these, an African counsellor should be able to listen and interpret stories, have fair knowledge of African worldviews to be able to listen and read behind the narrated story. Africans do not usually express their beliefs and practices in words as much as they live them, so a counsellor should not only focus on the narrated story; he/she should be aware of indicators to probe. And lastly, counsellors should be able to probe, comfort, discern, interpret, empathise and edify counselees.

### 7.2.5 Chapter 6

The home-based care concept refers to care that is provided to people living with HIV/AIDS at home by family, friends, relatives and the community. This allows the person living with HIV/AIDS to stay at home and to be cared for as comfortably as possible, even to the point of death. Home-based care is a cheaper way of caring for the sick than hospital care. And in Africa, where health care facilities are scarce and the people are poor, it is the model that can be adopted practically.

Home-based care originated formally in USA in 1986 with the Committee on a National Strategy for AIDS (CNSA), but in Africa family care has been part of life, though it was not formalised. However, as a formal structure, home-based care is done in three ways (three models), according to Uys: integrated home-based care, single service home-based care and informal home-based care.

*Integrated home-based care* links the service providers (medical) and families. It is the most effective model. It attempts to enhance support and collaboration between different components (families, community caregivers, support

groups, NGOs, and community-based organisations). In this model, referral is done between partners as trust is built, and it develops capacity in all partners. All care is given based on palliative care standards. However, in Africa, especially in contexts of poverty, it is largely inapplicable due to scarce health-care resources.

In *single service home-based care*, one service component (a hospital, a clinic, an NGO, or a church) organises a home-based care by recruiting volunteers, training them, and linking them to HIV/AIDS affected people and their families in the homes. Therefore, since churches are the most strategically located institutions in Africa, they should play a leading role in single service home-based caring, linking with NGO working in the areas.

In *informal home-based care*, families care for their members at home with the informal assistance of their social network. Nobody has any specific training or external support, and there is no formal organisation. These people get little or no external support and assistance. It is the least effective, but the majority of HIV/AIDS care in Africa falls into this category; hence organisations that may provide single service home-based care within an area, like the church in our case, should identify informal home-care providers and support them.

### *7.3 Findings and Recommendations*

This research focused on how a person diagnosed as HIV positive (or in the AIDS condition) and the significant others may get healed. Thus it deals with life beyond infection, as the title states.

Life beyond infection, the aftermath of the disclosure of the HIV-positive status, focuses on how the HIV-positive person reacts, how significant others react, and how these reactions might impact on symptom development (physical, psychological, social, economic, spiritual), i.e. on the course of the disease, and how the infected person and affected people cope. The role of HIV/AIDS care and counselling is to facilitate and enhance the infected person and affected people to cope - from the moment of disclosure until the terminal stage and eventual grieving and bereavement. This therefore means HIV/AIDS care and counselling is not a once-off exercise or a few sessions like, for instance, dealing with a marriage conflict, but a long process of walking the journey alongside the infected and affected people - through the stages of diagnosis/sero-conversion, asymptomatic phase, symptomatic phase, serious illness, the terminal stage, and grieving.

However, the journey (from disclosure to the terminal stage and grief) is a long one (approx. 8-15 years, though this varies) and it requires other people to be present for support. Thus there should be a model of HIV/AIDS care and counselling that satisfies these conditions - and we have suggested home-

based care. In addition, apart from the need for ongoing care that requires people's presence, in Africa it is arguably the ideal. There is a shortage of medical resources (material and human). It is difficult to ensure that care is truly patient-centred, that patients' worries are heard and addressed in a timely fashion (Dr Prabhu). The personnel only visit the sick when they have finished their routine work, which usually does not happen because of lack of human resources, e.g. in Uganda the nurse to patient ratio is 1:4300 and 88% of the population live more than 10 km from any kind of health facility. Furthermore, it is estimated that 50-60% people worldwide have no access to health care workers to address their medical needs. This therefore means home-based care can be a model that could be adopted for HIV/AIDS care and counselling in Africa. Moreover, this study highlights the view that home-based care should be encouraged as one of the non-ARV options, which should be scaled up with the same vigour as ARV drugs have been - but it is being ignored as a cost-effective intervention, while people rush for ARVs (AIDS Bulletin, October 2004).

This research found that, despite the facts in support for home-based care as an effective responsive paradigm to HIV/AIDS care and counselling, it is not given much attention. The phrase "home-based care" is often mentioned in HIV/AIDS discourse, but there is no serious reflection on the subject. The "neglect" of the subject is evidenced from the avalanche of HIV/AIDS care and counselling literature that either mentions it sporadically with no proper coordinated thinking, or totally ignores it (see introduction - research focus). Many Internet websites that deal with HIV/AIDS issues usually have only one line or paragraph on the issue. However, more disturbing in this study's findings from a theological perspective, including those who are involved in "HIV/AIDS theologising", is that many HIV/AIDS care and counsellors seem not to consider it important, judging from the extent to which they ignore it.<sup>1</sup>

What seems clear also from the literature is that the failure to recognise and harness the potential of home-based care results from a lack of well-ground theological principles that drive HIV/AIDS ministries. Most of the literature concentrates on unconditional love, acceptance, avoiding discrimination, and not stigmatising HIV/AIDS-affected people. In so doing, they argue, they would be enfleshing/embodying the gospel like Jesus who loved, cared, accepted and did not discriminate against people during his earthly ministry. Basing on this argument, then, the church or congregations are challenged to care, i.e. to do likewise.

This theological locus, though it appears clear in Scripture, overlooks an important issue in the church, i.e. that of thinking systemically in family terms.

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<sup>1</sup> See introduction for a list of some publications on HIV/AIDS care and counselling that either mention home-based care briefly or totally ignore it.



Darrel Guder's (2000) book, *The Continuing Conversion of the Church*, though focusing on Western audiences and Church mission (evangelism), highlights a way that might steer congregations in this direction, which he calls church conversion. Congregations/churches should continually be converted in their practices (not only in gospel proclamation!) so that they can change their attitude in order to be able to practise the "unconditionals" - love, acceptance, indiscrimination, etc. - that Jesus demonstrated.

Guder rightly argues that the missional church's theology and practice of evangelism should be rethought and redirected to address the contemporary challenges, which include sweeping changes in its institutional structures and practices. However, though Guder focuses on mission and evangelism, the church in addressing HIV/AIDS should also adopt this approach. Conversion entails changing congregations and church institutional practices - how we view and respond to our brothers and sisters with HIV/AIDS and the poor (i.e. attitude). It should be underlined that it is when the church/congregation is converted (also in attitude - *metanoia*) that it would view its being in the light of Jesus' ministry, otherwise any ministry that is not motivated through pneumatology resulting from transformed life will not last. Hence congregational mobilisation should also target members' conversion in order to truly function systemically.

Continual congregation/church conversion with respect to HIV/AIDS and poverty has double implications that seem to be under-emphasised and at times ignored in HIV/AIDS care and counselling discourse. Firstly, the church would be in line with God's expectation of his followers to be "Christ-like, i.e. Christians", who are pneumatologically transformed and act in "word and deed". Secondly, these people would share this message of reconciliation, peace and hope in Jesus with HIV/AIDS-affected people, who desperately require Christ's soothing.

However, while we are not recommending a kerygmatic approach, we should understand that the framework in which church members may truly conceive themselves systemically as a family is when they are part of Christ's family. Christ's family implies that the church (*koinonia*) would view its ministry of love, care, acceptance, lack of discrimination, etc. as its being and means of sharing God's Kingdom in Christ (eschatology). Thus HIV/AIDS care and counselling ministry should not only be perceived as bringing healing to the infected and affected through love, acceptance, lack of discrimination, etc., but this should be coupled with the promises of the gospel. In linking these two horizons we therefore recommend a perspective model. This combats the prevailing unbalanced over-emphasis of actions (love, acceptance, indiscrimination, etc.) and under-emphasis of sharing of the gospel (God's promises in Christ, i.e. salvation brings healing). Pastoral or Christian healing is

about God's promises in the gospel, i.e. *promissiotherapy* through the conduit of *koinonia*.

The under-emphasis of gospel sharing in HIV/AIDS care and counselling, however, may not necessarily signify reductionism. It mirrors the confusion and lack of clarity on how the gospel and actions in HIV/AIDS care and counselling merge. Care providers seem to feel that sharing the gospel may be "kerygmatic manipulation". Shelp and Sunderland (1987) made this point clear that AIDS ministries should not be evangelistic. However, though kerygmatic manipulation should be avoided, care providers should understand that failure to share the gospel to despairing HIV/AIDS affected people is as good as being unloving, not accepting, and practising discrimination. HIV/AIDS ministry should be holistic and the gospel is central to it. Pastoral therapy (healing) is about salvation. Thus it should be stressed that if HIV/AIDS pastoral/Christian care ignores its resources, i.e. Scripture (gospel), prayer and sacraments, it becomes indistinct from any other counselling approach and consequently losing its therapeutic dimension. Gospel sharing therefore should be central in all HIV/AIDS caring ministries.

However, the centrality of the gospel does not suggest that the *koinonia* healing role is not crucial. Believers should embody the gospel message as an instrument of healing. The church (*koinonia*) amidst the HIV/AIDS pandemic should be challenged to practical intervention (embodiment) and should be driven by a practical theological ecclesiology. This research therefore suggests congregational HIV/AIDS and poverty ministries driven by a practical theological ecclesiology of the family system. The family in Scripture has been the locus of God's promises, e.g. Noah, Abraham, Isaac, Jacob, David and households in the New Testament. But importantly, the church is designated as family (metaphor). The family of believers (Gal. 6:10) or family of God (1 Pet. 4:17) becomes a dominant picture in the New Testament. Both Jews and Gentiles are members of God's household (Eph. 2:19).

The church as a family system entails connectivity. A system is a collection of interrelated components and the existing relationships among the components. It is a collection of people whose behaviour is related in a particular way and the relationships that exist among these people. A systems perspective is an inclusive means of examining the nature, function and health of families. Each part of a system (person) is connected to, or can have its effect upon, every other part. Each component, rather than having its own discrete identity or input, operates as part of a larger whole. The components do not function according to their nature, but according to their position in the network. This network "oneness" can be a healthy balancing of affectionate connectedness and respectful separateness, and it can be an unhealthy "stuck togetherness" at one pole or an emotionally distant abandonment at the other extreme.

This study revealed that the church/congregational family system is depicted by metaphors/imagery such as family, which emphasises Christian connectedness. And as a system, the church is made of Christians attached or connected as a unit. This system (i.e. communion of believers – *koinonia*) entails that the members' experiences – sorrows, pains, joy, etc. – are shared. The *koinonia* (system) principle compels them to identify with one another in all circumstances. They are encouraged to carry each other's burden (Gal. 6). Thus if there are poor and HIV/AIDS affected people in the church/congregation, members would be empathetic to comfort and provide for them, which brings healing to the individual and consequently also healing to the whole system.

Systems theory argues that when a person is treated in isolation from his/her connections with others, as though the problem were solely his/her own, fundamental change is not likely to occur. The problem can recycle in the same or different form in the same or different member. Thus trying to cure a person in isolation from his/her family is as misguided and ineffective as transplanting a healthy organ into a body whose unbalanced chemistry will destroy the new one as it did the old. A problematic person within a system is just an identified patient in which the systems problem surfaced. This means in a church that when a person is diagnosed HIV positive and suddenly stops attending church, probably the person is being stigmatised, and so the church needs healing, not necessarily only the HIV-positive person. The church should be treated, which means in the researcher's language that it should be "converted" (change attitude). Systems theory in the context of HIV/AIDS and poverty means that church/congregational therapy should not try only to calm the stigmatised or rejected individual, but to change the entire system (congregational attitude) so that rejection and apathy are dispelled.

Furthermore, the concept of homeostasis (balance) in systems theory assumes that systems strive to maintain their identity (status quo). This concept explains the resistance that certain churches/congregations have to incorporating initiatives in response to contemporary challenges such as HIV/AIDS and poverty. In maintaining the system balance (homeostasis), congregations may prefer having apathetic, uninvolved or downright incompetent members, while creative thinkers and members who challenge others to be involved are suppressed.

A congregation system seeks to keep itself balanced (homeostasis). It resists change. The concept of identified patient identifies the symptom of the system through the surfacing of pathology in a member. And, within systems theory, differentiation is concerned with the resources available within a family system for helping it to overcome its homeostatic resistance. Differentiation is the capacity of a member to define his/her own life's goals and values apart from the surrounding togetherness, to say "I" when others are demanding "you" and

“we”. For instance, in a church/congregation where members are not concerned about the poor and HIV/AIDS-affected people, differentiation provides the basis for an individual to perform the appropriate action – “helping the needy” – but at the same time maintaining a loving relationship with fellow Christians who are uninvolved and oppositional.

This study therefore found that the congregational systems approach provides a diagnostic and analytical framework for addressing congregational apathy about community and societal issues such as HIV/AIDS and poverty. Furthermore, it provides ways of congregational therapy (healing through changing its attitude).

The congregational family system as revealed in the study compels Christians to shift from individualism to balanced communalism. The communion of believers (*koinonia*) entails that the people’s needs are identified by the believers themselves (bottom up) and then mobilise interventions. However, the obligation to care and support one another goes beyond fellow Christians to community and society. Although the New Testament emphasis is on giving material to those who are part of the church (Acts 11:29; 2 Cor. 8:4; 1 Jn. 3:17), there is still an affirmation that it is right and one is expected to help people even if they do not respond with gratitude or acceptance of the gospel message. Jesus said, “Love your enemies, and do good, and lend, expecting nothing in return... Be merciful, even as your Father in heaven is merciful” (Luke 6:35-36). Jesus’ exhortation is that we are to imitate God in being kind to those who are ungrateful and selfish. Besides, we have his example – he laid hands on everyone and healed indiscriminately (Luke 4:40). This therefore should give encouragement to carry out deeds of kindness, and to pray for healing and other needs in the lives of unbelievers (community) as well. Ministries of mercy, as Grudem (1994) rightly points out, may also include participation in civic activities or attempting to influence government policies to make them more consistent with biblical moral principles. In areas where there is systematic injustice manifested in the treatment of the poor and HIV/AIDS, and the marginalised (and downtrodden), the church should pray and – as it has opportunity – speak against injustices (*paraklesis* function).

The obligation for the church family system to care for others is not too complex to discern from African society. The concept of *umuntu ungumuntu ngabantu* (a person is a person through others) compels one to care and provide for others. In Scripture, apart from the observation highlighted earlier, it can easily be learnt from the *Imago dei* principle. We should care for other human beings created in God’s image despite religious preferences and inclinations. In this sense, therefore, we advocate a theology of action towards the poor and HIV/AIDS-affected people driven by the congregational family system principle. Thus pneumatological persons within a congregation system nurture each other through the gospel and material support (inward ministry

focus), while at the same time share the gospel and provide material support to community people (outward ministry focus) who are poor and affected by HIV/AIDS.

The congregational family system is not alien to African people, as mentioned earlier. It dovetails well with the African communal approach. As a way of coping in sickness and suffering (including HIV/AIDS), the extended family or community walk the journey with the suffering person through participating with him/her in rituals or any other pain- or suffering-alleviating exercises. The person is never left alone confined in a hospital isolation room or hospice, but the loved ones (family members) always congregate around him/her. Therefore since congregation/church members come from such a culture of community care, the African church should utilise this principle. The direct link between church/congregation system and community is that a church is a subsystem of the community, hence the congregation can tap this ethic and design effective congregational home-based care ministries that reach the wider community.

However, this study noted and emphasised that African traditional practices may not necessarily translate to effective and acceptable Christian practices, though there is reason to contend that they can be harnessed and channelled for effective care. The juxtaposition of African practices and Scripture does not and should not in any way suggest that the two are on a par. The healthy relationship is that the African church should borrow from the rich elements of the culture, while Scripture aligns the practices. Thus, in case of conflict, Scripture takes precedence and should always transform and influence cultural practices.

It is suggested on the basis of this research that HIV/AIDS in Africa should be treated together with other sicknesses and suffering, otherwise focusing on it exclusively might cause stigmatisation. Besides, it is also perceived to be personalistically caused like any other sickness and suffering. A personalistic system perceives disease and sickness as caused by an active purposeful intervention of an agent, who may be human (a witch or sorcerer), non-human (a ghost, an ancestor, an evil spirit), or supernatural (a deity or other very powerful being). The sick person is viewed as a victim, the object of aggression or punishment directed against him. This view is in contrast to the Western naturalistic system that explains sickness in impersonal, systemic terms. Disease does not stem from the machinations of the angry being, but rather from natural forces or conditions such as cold, or by an upset in the balance of basic body elements. Thus African people, ingrained with the personalistic or supernatural worldview of sickness, though they may hold that a virus causes HIV/AIDS, link or associate it with personalistic or supernatural means. One old man in rural Zimbabwe, when asked what he thinks about HIV/AIDS despite the knowledge that HIV/AIDS is caused by a virus stated: *vana*

*havachanzwi* (lit. children are disobedient or rebelling), implying that young people are breaking societal taboos and this is causing HIV/AIDS.

The association of HIV/AIDS with supernatural causes, i.e. blaming external factors such as witches and sorcerers for HIV/AIDS, has a crucial psychological function. It removes the responsibility from the HIV positive person, family and society. This hypothesis fits well as a comprehensive explanation within the African worldview of sickness, thereby removing feelings of guilt and anxiety. The witchcraft beliefs also resolve the community's need to explain why some people who are at risk do not contract HIV. Furthermore, due to HIV stigmatisation, attributing HIV/AIDS to witchcraft helps the family not to be stigmatised by the community.

However, this study reveals that attributing HIV/AIDS to supernatural causes also has negative implications. The belief that everything is caused by an external, supernatural beings implies that individuals may not be held responsible and accountable for their own behaviour. HIV calls for responsible sexual behaviour. In addition, this thinking needs to be seriously confronted and challenged in the case of HIV/AIDS. It creates unnecessary conflict among (extended) family members, since they are often the ones accused, and yet the cause is known. Therefore, in designing HIV/AIDS care and counselling ministries, this African worldview should be addressed fully to dispel denial and encourage status acceptance, which leads to healing.

This study also revealed that the over-assumption by many African writers that healing in Africa is achieved through family or communal therapy should be seriously re-thought. Sickness and suffering (and HIV/AIDS) healing in Africa (i.e. African therapy) entails family or community members coming together to perform rituals for healing. They consult diviners who offer an explanation for the cause of the sickness and then recommend the appropriate ritual to restore the balance. The exercise of coming together and consulting a diviner in times of sickness and suffering is to determine "who" caused the sickness (a witch or ancestor) and then "why" it was done. The "who?" and "why?" questions have instant answers and then recommendations for the appropriate ritual follow. Thus the "why?" question for Africans is not a meaning question, but it has an instant answer. However, in the context of HIV/AIDS suffering it is known that a virus causes it, so any divination only brings conflict and hate among family members (as pointed out earlier).

African counselling and therapy that the African writers espouse has a serious downside, which is overlooked in these writers' over-assumption. Many Africans hold to the traditional cause and effect supernatural worldview. And in times of sickness and suffering (HIV/AIDS) in family and community gatherings one is usually expected to conform to the non-Christian rituals. It is respect to oneself and the elders or community for the individual to take

advice (which is the usual form of counselling) to maintain peace not only with the living elders but also the living dead. Refusal to conform, i.e. accept healing and restoration rituals recommended by the elders, may cause expulsion (sanction), i.e. being cut off from the network of relationships (family members and community), which aggravates pain and suffering. This dynamic in African counselling and therapy is usually overlooked or over-assumed as a crucial complicating factor in African community healing.

The other issue that is approached simplistically or reductively by African writers is the over-emphasis on stories as diagnostic focal issues. Story analysis in Africa, as in the West, is vital in counselling diagnosis or assessment (narrative therapy). But in Africa the amplification of stories is a misguided and inaccurate attempt by African writers in a quest to come up with what they can call an “African approach”. It should be stressed that in African diagnosis or assessment, a people’s worldview is crucial. A story is just the beginning. Tebogo Mazibuko (2004), in her paper on *Ubuntu*, revealed this dynamic. She rightly commented that African people don’t express their beliefs in words as much as they live them. They can easily profess Jesus Christ during the day and consult diviners at night. If one focuses on stories and is not aware of the fundamental underlying beliefs and practices (worldview), one may overlook the appropriate intervention. Thus a counsellor should know and take the African worldview as crucial in diagnosis. One should know what issues to probe, i.e. what indicators in the story can lead you to crucial issues that hinder healing, like family or community pressure to conform. Guidelines suggested in Chapter 5 on focal issues in African pastoral counselling diagnosis can be a useful starting point.

This study therefore reveals that the challenge in pastoral care and counselling in Africa in sickness and suffering (HIV/AIDS) lies in confronting people’s worldviews in order to transform and align them with biblical thinking and worldview (which brings Christian healing). Thus they need to hold tenaciously to God’s promises in Christ (gospel) through the enabling of the Holy Spirit, when there may be threatening extended family and community pressure (system). In Africa, therefore, pastoral care ministry, focusing on a congregational systems approach, should be designed with the following in mind:

- ≈ A congregational (*koinonia*) systems approach, which does not view a believer in isolation but within a congregational network, should be encouraged. The sick and suffering (HIV/AIDS) who embrace biblical thinking and God images, and refuse African traditional healing rituals, and so may be in conflict with the network of the extended family and community, should find a buffer or support base through fellow believers (*koinonia*). Congregational (family system) home-based care therefore

should be ready to supplement or, where necessary, replace family or community care.

- ✧ Congregational members (*koinonia*) should be ready and prepared to buffer the person materially and spiritually. When one is cut from one's traditional network, it may entail material loss, hence fellow believers (*koinonia*) should be ready to provide accommodation and food parcels. Thus pastoral care in Africa should not and cannot be a once-off exercise, but entails ongoing care and counselling (nurturing).
- ✧ Congregational members (*koinonia*) who are the pastoral care providers should be patient with the members who struggle to embrace Christian modes of healing (gospel promises). It is a painful decision that may psychologically haunt one to think that one is in disagreement and conflict with family members and community. As one counts the cost of each decision - cutting oneself off from relationships or rejecting God's promises in the gospel - fellow believers should be patient and persistently encourage the individual. "Be merciful to those who doubt" (Jude 22).
- ✧ Congregational systems (*koinonia*) care, to be sustainable, should always try to assist the affected members to remain connected to their relatives (family and community). When such members are able to stand and overcome the crisis successfully, through God's grace, they will be exhibits and testimony of God's victory and hope to the rest of the family and community members, thereby becoming the instrument of communicating the gospel of hope to others. "You are the salt of the world. A city on a hill cannot be hidden. Neither do people light a lamp and put it under a bowl. Instead they put it on its stand, and it gives light to everyone in the house" (Matthew 5:14-15).
- ✧ Congregational (*koinonia*) care in poor communities should generally be sensitive and be aware of the immense need of its people and community. As an institution it should stand between the informal home-based care providers and outside agencies that provide resources in order to holistically support its members and the community.
- ✧ Pastoral care providers should be aware of (i.e. should be able to assess) the conflicting issues between Christianity (Bible) and the African culture (worldview) in order to provide appropriate care and counselling.

Congregational (*koinonia*) HIV/AIDS care, which has been advocated in this research, has been identified as the appropriate model in poor contexts. The study showed that the church is the only institutional structure, apart from the school, in these contexts, hence it can be a vital link to the community. While this study found that informal home-based care in HIV/AIDS is the practical situation in most African poor homes hit by the epidemic, the model fails to address its associated problem, i.e. poverty. Hence these people should be linked to a congregation.



The interplay between poverty and HIV/AIDS works in two directions. Poverty increases poor people's vulnerability e.g. through risk behaviour (i.e. poverty is a push factor), and accelerates immunity depletion due to poor nutrition (i.e. the poor probably die sooner than wealthier people). The chief risk behaviour is, among others, selling sex or gift sex, which is complex to contain because it is entangled with poverty. Some people prefer dying of HIV/AIDS-related conditions, which takes a long time, than painfully dying of starvation (hunger) in few days. For these people HIV/AIDS prevention is not a priority; hence, to achieve the desired prevention results, programmes should be holistic. This means HIV/AIDS prevention programmes should also focus on poverty alleviation at the same time. On the other hand, HIV/AIDS exacerbates poverty as the potentially productive person in the home becomes powerless and draws from his/her savings. Household income is eroded through high medical and funeral costs. Employers may also be reluctant to employ people living with HIV/AIDS, thereby impoverishing them more. Orphans may not attend school, thereby becoming the poor of the succeeding generation (poverty vicious cycle).

However, the study revealed that, though there appears to be a clear relationship between HIV/AIDS and poverty, a simplistic approach should be avoided. The poverty-HIV/AIDS interactions are myriad, complex and not fully understood. The Nelson Mandela comprehensive research project on HIV/AIDS (2002) in South Africa, and the Zimbabwe National HIV/AIDS estimates by the Zimbabwean Ministry of Health and UNAIDS (2003) (which are likely to be applicable in many other African countries as well) revealed that, though rural people are poorer than urban people, HIV/AIDS is less prevalent, while in the urban areas it is higher. This is true even with respect to countries: South Africa and Botswana are relatively richer than many African countries, but they have very high HIV/AIDS rates (in fact, Botswana's is the highest). Furthermore, the research showed that the factors that are usually attributed to explain the high HIV/AIDS rates in Africa (e.g. polygamy and young brother taking over the dead brother's wife), based on empirical research (the Nelson Mandela HIV/AIDS research) does not hold water. Therefore simplistic explanations for the widespread African HIV/AIDS scenario should be discouraged. HIV/AIDS workers should always do contextual analysis rather than focusing on generalisations.

The study further revealed that poverty is not an abstract concept. It affects people directly in whatever context they are. They see, feel and experience it. Thus poverty is experiential and contextual. Every community is aware of the poor among themselves. In designing congregational ministries, members should use their contextual understanding of poverty to determine who are the most needy in the community.

The congregational home-based care model that is advocated in this research precisely attempts to address the twin challenges of poverty and HIV/AIDS. It links the poor and HIV/AIDS-affected people in the community to the church institution. Informal home-based care that many African people in Africa are involved in, though practical, is difficult to coordinate and recognise. Many poor people, especially women (who are the majority of home care providers), are easily overlooked or neglected by affluent and male-dominated structures. These people may not be recognised because they are not linked or connected to any formal or credible institution. The value therefore of congregational home-based care found in this research is that the church in a community is a formal and credible institution. It can access material resources from agencies (e.g. NGOs or government), while at the same time it is closely linked to the community through its members. Thus the church becomes a vital link and channel of resources to informal-home home-based care providers as a “go-between”. This approach therefore may adequately and holistically address HIV/AIDS and poverty as related issues.

Pastoral care and counselling in Africa thus need to address the twin challenges of HIV/AIDS and poverty, and provide effective support systems to families during times of crisis as well as during the terminal stages and bereavement care. They should move away from a counselling room approach towards a congregational systems approach. The congregation can achieve this through designing a congregational home-based care ministry that is focused not only on nurturing its members but also on the needs, pain, and suffering of the community and society. This entails that faith community members (*koinonia*) walk the painful journey with HIV/AIDS-affected people from the moment of disclosure until the terminal stage. *Thus the journey of life beyond infection (i.e. after disclosure of the HIV-positive status) requires selfless and sacrificial service on the part of the koinonia. The gospel promises should not merely be lip service but enfolded and embodied.*

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Statistical data confirms beyond a doubt that sub-Saharan Africa is a very poor region with the highest HIV/AIDS prevalence in the world. The region has poor and limited health facilities and resources (personnel and financial). Such a scenario is conducive to the increase of the HIV/AIDS pandemic. HIV/AIDS and poverty are intricately linked and they interplay. Responding effectively to the situation requires a relevant, applicable and holistic model. This publication carefully describes the HIV/AIDS pandemic and how it is understood in some African contexts, which hampers prevention initiatives. It also delineates the complex nature of the poverty and HIV/AIDS interplay. To address the situation, a family systems practical ecclesiological theology and approach to HIV/AIDS ministry, and a pastoral counselling approach that derives from and is sensitive to the African context, are proposed. The proposed model comprises congregational home-based pastoral care that integrates the church and African extended family systems for effective HIV/AIDS ministry.

*Vhumani Magezi* is a Researcher with the AIDS Foundation of South Africa (AFSA). His research and publications are on systemic, ecclesiological and community responses to poverty and HIV/AIDS, and Pastoral counselling issues in Africa. He worked in various capacities for several organisations, including lecturing in Practical Theology and directing Postgraduate Research.